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PUBLIC HEALTH NURSING

VOL. 44, NO. 10 OCTOBER 1952

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ANNA FILLMORE, R.N., *General Director,* National League for Nursing

RUTH FISHER, R.N., *Director,* Department of Public Health Nursing, NLN

PUBLIC HEALTH NURSING

Editor: HEDWIG COHEN, R.N.

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In January 1953 the National League for Nursing's new official magazine NURSING OUTLOOK will make its appearance. This will continue the coverage of PUBLIC HEALTH NURSING and will also carry material in the overall fields of nursing education and nursing service. Subscription rates of NURSING OUTLOOK are $4.00 per 1 year and $6.50 per 2 years. For foreign subscriptions add $1.00 per year; for Canadian, add 50 cents per year.

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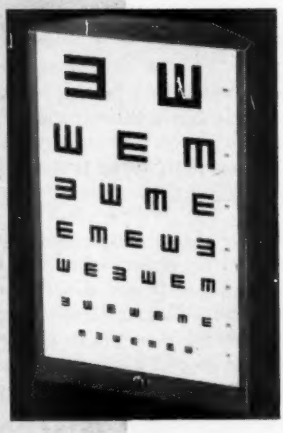

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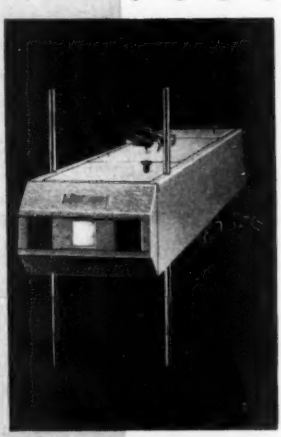

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and Its Important Contribution of Essential Amino Acids

Although the daily allowance of protein recommended for human beings has been established for some time,[1] only very recently has a recommended daily intake of individual essential amino acids been proposed.[2] These new criteria now give a more accurate means for nutritionally evaluating the protein contribution of meat than was possible just on the basis of the gross amount of protein meat provides.

The table which follows gives the proportions of the recommended daily intake of individual essential amino acids provided by six ounces of cooked meat, the approximate average per capita daily consumption in the American diet. Note that though furnishing about 52 per cent of the daily protein allowance for a normal adult male, six ounces of meat supplies more than the recommended daily intake for a majority of the essential amino acids and a goodly proportion of the recommended intake of the remainder.

Percentages of Recommended Daily Intake of Eight Essential Amino Acids and of Protein Contributed by 6 Oz. of Cooked Meat*

Essential Amino Acids	Beef[3]	Lamb[4]	Pork[4]
L-Isoleucine	141	121	127
L-Leucine	150	120	125
L-Lysine	202	163	172
L-Methionine	42	34	40
L-Phenylalanine	70	63	70
L-Threonine	160	169	183
L-Tryptophan	90	90	100
L-Valine	136	107	113
Protein	56	49	51

*In the calculations, averages of the percentages of protein in six different cuts of each type of cooked meat were used, as were averages of the percentages of the amino acids in the protein of the respective cuts.

Every kind and cut of meat is not only an excellent source of the essential amino acids but also of the nonessential amino acids, the B group of vitamins, iron, and other essential minerals. Morever, meat is rapidly and almost completely digested, has a stimulating influence upon appetite and digestion, and gives a gratifying sense of satiety. All these nutritional and physiologic advantages of meat fully justify its prominent place in normal diets of persons of all ages and in many special diets.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Public Health Nursing in the NLN

DURING THE summer months in which gears have been shifting, the wheels turning quietly—and we hope somewhat smoothly—the National League for Nursing has gone into action. In September NLN members received ballots to vote for steering committees of the Departments of which they are members and for the nominating committee which will prepare the NLN slate for next year. Members from all over the country are coming to headquarters for meetings of new important committees and for conferences on NLN activities.

In the Department of Public Health Nursing the usual NOPHN activities have been carried on, as it is this department that is responsible for a program similar to that of the former NOPHN. It continues the broad objective promoted by the older organization during the forty years of its history—the development of the best possible public health nursing service for all people in every community and the development of educational programs to prepare nurses to give this service. The staff of the department will continue to serve its members—individual and agency—and others interested in public health nursing services, through correspondence and office and field consultation, and will increase these services and add others as resources permit.

Everyone recognizes the pressures under which local services function today, the heavy demands under which public health nurses work. There are problems—local, state, and national—and for the local agency the greatest of these seem to be local problems. Yet it is obvious that no significant planning can be done successfully without involving larger groups. It is the national organization, in touch with services and developments throughout the country in rural and urban centers, that best can help with problems.

It is through the national organization that community public health nursing services, through active membership and real support, can make themselves a part of the national stream of activity. The more than 8,500 individual members and 400 agency members are the channels through which the programs of the Department of Public Health Nursing are carried out. But the potential membership is much greater and it is only as all those interested in advancing public health nursing demonstrate their concern by becoming members of the National League for Nursing that the department can grow and reach out across the country and become truly the voice of public health nursing.

SEVERAL YEARS ago in an earlier editorial we explored this same thought. We think we well may refer back to that discussion: "The job of public health nursing does not stop at the geographical boundaries of any local community. There is an important part of the job that can be carried on only at the

national level by a voluntary membership organization to which agencies as well as people associated with those agencies belong. For effective and efficient programs public health nursing services need a national medium through which they can meet on common ground, pool ideas and experiences, and arrive at standards that are based on a comprehensive point of view, broader than that of one community or state. They need a central bureau to provide field service and information, to conduct special studies, and to issue guides and other helpful publications.

"They need an informed organization that can speak for them nationally and represent them on committees and commissions of other national health and welfare organizations and groups with whose local counterparts public health nursing services work in their own communities. They need a national organization that is a tangible symbol of their common purpose."

It is this part of the job that the Department of Public Health Nursing of the NLN is trying to do. Every member strengthens the organization and the department. It is only as we do things together, from the preplanning stages to the end evaluation, that members and the national organization grow strong together. And today with the big jobs facing all of us we need strength in public health nursing, locally and nationally.

The Cost of Student Programs

THE WORKING Committee of the Project, Analyses of Special Cost Items in Public Health Nursing, in presenting its report* was well aware that there are many factors other than financial costs which enter into a student field instruction program. In fact, it was the committee's hope that an article pointing out the intangibles and plus values of student programs would be prepared and published shortly after the committee's findings were released.

On page 531 Ruth Hubbard, a public health nursing administrator of note, who has also been an active participant in the work of the NOPHN Education Committee, describes the development of field instruction programs in public health nursing services. She relates the many values of such programs from both the agency and the university points of view. As an administrator she is well aware of an agency's need to approach student programs costwise, but she also gives recognition to the assets not readily measurable in dollars and cents.

The project committee has worked out a method for determining student costs on the basis of average costs. Application of this method gives us probably our first realistic information on student costs. But it is important that we weigh such costs within the total context of the student program picture—and Miss Hubbard's story does much to bring the picture into clear focus.

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* NOPHN. Supplement to cost analysis for public health nursing services. 1952. New York. Available from NLN.

Field Instruction: Costs and Benefits

RUTH W. HUBBARD, R.N.

THROUGHOUT the course of their existence in this country public health nursing agencies have written firmly into their charters the statement that service to patients in their homes was a primary objective. Yet each new agency learned almost immediately that the preparation of public health nurses who form the staff became a secondary aim of basic importance. And because the pioneers believed that the service they desired to create for one community should be available throughout the land they recognized early a responsibility to prepare workers for other communities. With equal foresight they soon realized that inservice training alone was inadequate to give the full range of preparation needed and thus became earnest promoters of formal university programs. Although undoubtedly the potential service value of a student program intrigued some directors and boards, hard pressed for personnel and funds, clear-thinking members of both groups recognized the ultimate fallacy of such an approach. The resultant appearance of educational directors or student supervisors on the staffs of agencies early in the twentieth century gave significant emphasis to the conviction that students were primarily interested in learning and that they required the attention of a qualified staff member rather than the piecemeal assistance of persons with other responsibilities.

As universities developed programs the eagerness of service agencies to offer field experience was matched by that of the faculties who sought such openings for their students. The agencies obviously knew from experience —or the lack of it—the value of prepared personnel. The faculties knew, as teachers, that learning must be accompanied by appropriate practice.

From the beginning, therefore, the service and the educational institutions have recognized at least one common function—although stated in reverse order—that a sound service to patients has an educational value for prospective workers and that a sound education benefits service through its graduates.

With the improvement in business methods which has accompanied the expansion of service agencies in the last forty years—brought about by contractual agreements with groups purchasing their services, by a growing desire to be useful to all types of patients, and by an enlightened society that saw no value in inefficient use of contributed resources—the idea that educational services to universities also have a determinable value naturally emerged. But practical methods for determining such values lagged behind its recognition. In general practice agencies have established (often arbitrarily) tuition fees for affiliation or observation offered to basic students and universities allocate part of the tuition fee for credits earned through field work. These arrangements have been valuable in establishing mutual recognition of the values offered and received. They have aided in the development and acceptance of standards to be met by both parties to assure student benefit and in the maintenance of a continuously high standard of service to patients.

Yet arbitrary or estimated tuition fees provide an incomplete solution if accurate cost analysis is lacking. This is as true in educational service as it is in direct service to patients. It is not surprising therefore that

Miss Hubbard is general director, Visiting Nurse Society of Philadelphia.

there were urgent requests for special consideration of student costs when the preparation of a supplement to the manual, Cost Analysis for Public Health Nursing Services[1] was undertaken.

The cost study committee which has now submitted its report[2] supplies a method for determining student costs on the basis of average costs. In section II of the supplement to the manual the procedure is outlined by which an agency may prepare to study all or any of its several student programs. The findings of one agency in carrying through the process are used as an example. Further, it enumerates in detail the application of the method to one group of students and presents an analysis of the results as a guide to those interested in studying their own experience. At first glance readers (educators, administrators, and board members alike) may be concerned at the fiscal findings in the sample. They seem to predicate appreciably higher costs than have been estimated or determined by present methods. The figures could be disturbing were it not for the timely reminder that further application of this method is necessary to develop a pattern and to provide bases for appropriate comparisons between one agency's cost with one type of student and other agencies' costs. This cannot be stated too emphatically.

ALL OF US are concerned to know the true state of affairs costwise in our agency administration. For years we have depended upon accurate costing procedures in order to do business properly with other agencies. But we have equally maintained our policy of free or partial payment for services rendered to patients in need without ability to pay. The cost analysis method of 1950 has enabled those official and voluntary agencies who are using it to make important advances in their own analysis of their work and to improve the efficiency of their service while facing realistically the actual costs of operation. The method is especially useful in aiding an agency to determine soundly its ability to develop or maintain certain parts of its program and correspondingly to justify needed services at relatively high cost. In these days when personnel in short supply teaches us to revise the limited value we have placed upon the available time of professional staff, it is important to know accurately the price we pay for the use we make of this time. It is pertinent to note here that the special NOPHN committee reporting in May 1951 on recommended adjustments[3] reiterated the recommendation of the NOPHN Education Committee that public health nursing services should make their facilities for field instruction available on the basis of priorities established for the selection of students.

Cost analysis is admittedly, then, a basic procedure in any good service agency—whether the organization is philanthropic, tax supported, or income producing. But at least the first two types of agencies, by virtue of their objectives, are free to take other things into consideration in setting charges for service. Here we encounter the opportunity to consider values other than monetary which may obtain to the agency equipped to offer students field instruction. They are real, demonstrable, and historically—as indicated earlier—have played no small part in the behavior of agencies and universities to date.

When we take the position that we must know what a service costs we can without conflict accept the fact that the service sheet may be in balance although the ledger may not. Such a statement requires support in some detail. The experience of agencies offering field instruction to both graduate and basic students in more than one profession has resulted in the conviction that such programs have assets not readily measurable in dollars and cents. There are corresponding values for a university and they too merit mention.

Values for the Agency

It is not every agency that can offer opportunities to students. Universities and state boards of nurse examiners look for certain standards in an agency and when they accept an agency for field instruction for students the agency's position is enhanced among its associates and consumers of its services. This is not a negligible value—and it leads to a second value, improved status for recruitment of both field staff and supervisory personnel. Qualified applicants have learned to evaluate

a potential work situation in advance, and the presence of a student program is a proven favorable factor. Likewise, former students tend to seek professional practice in an agency where they have had favorable learning experience. Agencies employing these nurses have at least two useful guides in selection, a knowledge of the applicant's performance in a controlled situation and of her background in preparation. The resultant reduction in the period of orientation for which agencies must be responsible before the nurse becomes a fully functioning member of the group is an added asset. Agency studies have demonstrated the recruitment value of a student program during periods when employment opportunities have been both favorable and unfavorable.

THE SALUTORY relationship of staff stability and reduction in turnover to the presence of a student program may have less research to support it, but administrators are generally agreed that here, too, is a value worthy of mention. The costs of recruitment, introduction, and turnover are appreciable items in agency operation, whether known through cost analysis or only through wear and tear on responsible personnel. The ability to maintain turnover at a desirable level (complete stability, indefinitely, obviously has disadvantages) is influenced by program, personnel policies, and internal opportunity for advancement, as well as by the personal lives of the staff. The desire to try new fields may arise less readily when a broad program exists which challenges each worker to her full capacity. A program for students is an additional challenge which the consultants, supervisors, and the field staff meet, as do the educational personnel. The satisfaction of assisting the graduate who has chosen public health nursing as her field, the undergraduate not yet decided, those who have elected other fields, or observers from other professions, is no small one. In addition to personal satisfaction, however, there is the real opportunity for growth presented by students. It is when we teach patients or our future colleagues that we discover our own deficiencies and seek to overcome them.

This double demand upon the agency staff for professional growth, made by patients and students, creates a constantly stimulating environment, especially when the permanent staff member recognizes and embraces the opportunities to expand her own contribution thereby. The repeated arrival of new and questioning students precludes the possibility of undue rigidity in performance since the staff must constantly test their practices by the queries of the students. An agency with students becomes to some extent similar to a two- or three-generation family in which the younger members accept the guidance of those more experienced, while adding their own active and fresh points of view to the group undertaking. Although no one believes that the presence of students is the only way in which to keep alive the inquiring approach which every progressive service needs (patients themselves are perhaps the best stimulation) it is readily acknowledged that students are a decided asset.

It is obvious that an agency with a broad program is able to distribute its overhead expense over more cost centers and that one with a limited service has a smaller range for distribution. It is equally true that the overhead costs to be distributed in the former are greater, since the varied program requires qualifications in administrative personnel not called for in the agency with a limited service. The agency equipped to offer a diversified service which refrains from doing so is of course operating under a higher unit cost than seems necessary. It may have excellent reasons for doing so temporarily.

Values for the University

Professional education is committed to the position that clinical practice is an essential part of the student experience. Such practice to be useful must be controlled and supervised. It must take place without pressure for production. In fairness to the student it should occur in an environment of reality. For the public health nursing student this is found in an established service directed primarily to patient benefit and operated with sufficient stability to insure continuity of care for patients. These aspects are conceived to be more valuable for the learner than range of

program, desirable as that may be. It is in the living situation of the experienced service that the student learns best those factors which influence health and illness in family life and perceives her potential contribution through participation or observation. In such a situation she is enabled to appreciate the length of time needed to change attitudes or establish new habits—a period frequently longer than her own exposure to the field. The university able to secure field instruction for its students with an agency meeting its standards and which presents the reality emphasized here receives in its turn a rich intangible benefit. As an alternative to the creation of a service primarily for teaching purposes there is no choice. Universities constantly demonstrate their conviction of this by the support they give to the improvement of existing community services and their willingness to defer student placement until such improvements are achieved.

Further, the university whose faculty members are enabled to work in close association with the staff of such an agency finds another intangible but real benefit in the enriched material the instructors bring to the student in the classroom. Generations of nursing students have struggled with the gap between classroom procedure or precepts and practical performance in clinic, ward, or home. This gap between so-called ideal practice and that necessitated by a life situation is diminished when teacher and student are constantly in touch with the patient and his family. Ideals are not lost or standards lowered, but both become integrated in those actually desirable and possible of achievement by the patients for whom the service is designed. Real adaptation of established principles in good hygiene or nursing care to the home, the plant, or the school occurs when both teacher and student know the principles, the environment in which they are to be applied, and the families who must themselves make the application. The much esteemed admonition of the great Dr. A. Jacobi to his students "Never give up watching a patient"[4] is equally appropriate for the public health nurse.

Opportunity for research, the need for which is so keenly appreciated in the profession today, is more readily available to the faculty and the students of a university which has this close working relationship with its community service agencies. It is good to be able to mention here that the first issue of *Nursing Research* carried a report of a study[5] in which the facilities of a university and a visiting nurse association were jointly used by a graduate student in her research. This value actually works both ways for faculty, students, and staff benefit from joint consideration of service problems and not infrequently explore together in the search for sound solutions. The resources the university can make available here are matched by the agency's practical experience and its awareness of areas in urgent need of study.

ONE RETURNS to the realization that the educational institution (offering basic or graduate programs) and the service agency are interdependent and mutually benefited by association. In the past the educational institution may have found the service agency so ready to accept its function in education that it appeared unaware of any costs involved. This has occurred in some other professions whose schools traditionally made no provision for payment for practical experience. Such an arrangement often left much to be desired on both sides. In a more professional approach each party meets recognized standards and is prepared to accept definite responsibilities to insure valuable experience for students while safeguarding patient care. Certainly one of those responsibilities is recognition of the cost involved. Whether an educational institution meets all of the demonstrated financial cost or only approximates it may mean less to an agency, its board, or division chiefs than a readiness to acknowledge that sound clinical experience, as well as sound theoretical preparation, costs money. The first step is a satisfactory method to determine costs and the second, extensive application of the method to develop a pattern and to provide for appropriate comparisons. In the 1950 manual[1] such a method was presented, which has already proved that it is suited to the needs of official and voluntary agencies, who are using it widely. However,

this use showed that several areas needed further study.

Among these is the determination of student costs discussed here. It is now possible to take the second step in this area and by wide application to determine its usefulness. Based upon the accepted method of determination of average costs the student cost supplement[2] can be used easily by agencies already studying other service costs. The outcomes of such study will help to guide program planning because of a more accurate knowledge of costs, although there may continue to be a justifiable need to adjust charges for student experience. Results of such study may even lead to reevaluation of some experiences presently provided for students.

Cost is by no means the only factor to be considered in seeking or offering clinical fields for students. It is one of several identified here which together form the basis of a working relationship between a service agency and an educational institution. Assuredly others will suggest additional aspects of this relationship. These observations will have served their purpose if they awaken responsive comments and stimulate use of the method. For today, as always, concern with the preparation of the worker is basic to every effort to provide more adequate public health nursing service of high quality for the patient and his family.

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Insurance for Voluntary Agencies

J. WATSON BEACH

INSURANCE in the operation of a visiting nurse service today is a "must." Almost all agencies realize the need of certain types of coverage but are apt to overlook others. It seems hardly necessary to mention fire insurance, as that is generally accepted as a requisite by any individual or association owning property; but in light of the recent catastrophic tornadoes and several explosions what is known as extended coverage endorsement number four should be added to any fire policies, as this covers losses from windstorm, hail, falling aircraft, explosion, and smoke, as well as some other less common causes of loss.

Each association should check the compensation and disability laws of the state in which it is located to ascertain whether it is subject to these laws and qualifies under them. In most states it is the number of employees and the number of hours a week that each works which determine the answer. The benefits under these laws vary from one state to another but no association should run the risk of not insuring possible claims. In some states claims have run as high as one hundred thousand dollars for hospital benefits alone.

Automobile Insurance

Another obvious type of insurance is coverage on association-owned automobiles, protecting the association from claims when its cars injure people or damage their cars or other property. In buying this type of insurance the amount of coverage under the policy

must be given very careful consideration. Verdicts are steadily increasing in severity because of the depreciated dollar, and the necessarily increased cost of medical care and repairs to property. Limits of less than one hundred thousand dollars for injury to one person, three hundred thousand dollars for injury to more than one person in the same accident, and twenty-five thousand dollars for damage to property are proving inadequate.

It is not widely known that an association which allows an employee or friend to use his car on the business of the association may be held liable for any accidents arising from such use of the automobile; and there have been verdicts recently which have carried this doctrine to extreme lengths in dealing with eleemosynary institutions. It is practically impossible for an association to check up and be informed about the insurance that may or may not be in force on any particular car which may be engaged in voluntary work. It is, therefore, necessary to buy what is known as nonownership and hired car liability insurance with adequate limits, as stated in the preceding paragraph.

Comprehensive fire, theft, and collision insurance on an association's cars should or should not be purchased, depending upon the association's ability to replace cars that are destroyed without upsetting or unbalancing its budget.

Comprehensive Liability Insurance

Insurance protection against claims by members of the public for injuries received in the association's office building or at clinics maintained by the association should be carried also. This is known as comprehensive liability insurance. Included in the coverage under the policy should be a clause protecting the association from claims for malpractice or misfeasance on the part of employees, particularly nurses, while carrying out the functions of the association. Although the liability of nonprofit institutions varies greatly in different states, the courts are becoming more and more liberal in their interpretation of the statutes, and there is a marked tendency toward their holding such institutions liable for negligence.

Many associations have contracts to furnish services to cities, towns, counties, industries, and other groups. In almost all of these contracts there is a provision that the association shall hold the other party to the contract harmless from any claims. The comprehensive policy should carry a definite clause acknowledging the agency's responsibility and covering any liability arising therefrom in the names of both the contracting parties.

The foregoing paragraphs cover the "must" types of insurance, although there are other forms which should be considered, depending upon the particular circumstances existing in each association. Such other types of insurance include steam boiler insurance, fidelity bonds covering dishonesty of officers and employees, safe insurance, and inside and outside theft insurance.

Finally, consult your insurance agent and have him analyze your present coverages and exposures and fit your insurance to your specific problems.

Mr. Beach is an insurance executive and is a member of the Business Advisory Committee, Visiting Nurse Association of Hartford, Connecticut.

CAN YOU HELP?

American Relief for Korea reports that the most urgent relief requirement in war-torn Korea at present is for bedding for hospitals, orphanages, and destitute families. If you have any shoes, blankets, or clothes you would like to send to Korea please mail them to ARK, 52-15 Flushing Avenue, Maspeth, New York; ARK, 3146 Lucas Avenue, St. Louis 3, Missouri; or ARK, 10901 Russet Street, Oakland, California.

Old Wives on New Lives
A Study of Prenatal Superstitions

JUDY ETHERINGTON, R.N.

IF YOU are a woman have you ever stopped to figure out why you were born a girl rather than a boy? It's easy to explain. When your older brother spoke his first word it was "Papa." And what better proof could there be that the next twig on the family tree would be a girl? Now if he'd sputtered "Mama" instead, you would have been a boy and the whole course of your life would have been changed. The main point is that brother did his part. Ask any number of mothers about this and they'll either swear by the method or tell you they really don't believe it. But how could they tell mother that though it was good enough for grandma and good enough for her they're swinging around to the newfangled scientific outlook which is so much in vogue these days? You know, mothers are so conservative about such things.

Since man began to think he has been explaining the natural phenomena which he sees around him. If he has not been able to do so scientifically he manufactures his own explanations. In every culture, in every geographical area, local superstitions have developed from this habit. Even after a better understanding dawns this folklore persists, consciously and unconsciously. Thus man has explained the motion of the earth, the weather, and the physiological functions of the body. The more complex these are, the more wildly runs the folklore.

In explaining the mechanisms of life, science has done quite well in spreading information about the circulatory system and even about the cause and cure of disease, but the sexual and reproductive functions, those surrounded with an aura of misunderstanding, secrecy, and fear, still have a large part of the world baffled. Even where science has triumphed, where "civilization" reigns, man's superstitious self shows through around the edges to an embarrassing degree. Although we may laugh off our superstitions we are still remarkably influenced by them.

A survey of mothers on one obstetrical floor in the Grace-New Haven Community Hospital reveals what a wealth of such information about childbirth still circulates. There are those who swear by their beliefs. There are those who have been exposed to folklore but prefer to stick with science and consider these superstitions a good way to lighten their mental—and pelvic—load. There is the vast in-between, caught between superstition and science, which half believes or vainly tries to appear as though it does not.

A few of these old wives' tales seem to have some correlation with fact. The Czech custom of rubbing the nipples with ear wax to prepare them for nursing is an obvious parallel to the present medical practice of applying a lubricant prior to nursing, although today our esthetic self generally triumphs to the extent that we prefer some slightly cleaner substance. Some superstitions are an effort to explain the otherwise unexplainable, as the profuse number of reasons offered for the presence of birthmarks shows. Many hailing from a good Italian background can explain this without batting an eyelash. It's easy. The baby was "marked" because the mother was frightened during pregnancy.

One Italian mother explains her own "cream cheese" birthmark in this way: Her mother when seven months along the road to the delivery room was ordering some cream cheese

At the time this was written, the author was a student at the Yale University School of Nursing.

in her favorite delicatessen when one of the neighbors approached her from the rear and provided quite a mental jolt by touching her arm. That's where the daughter's birthmark appeared. Another woman tells how her mother during her pregnancy had a yen for some Italian coffee, the kind you grind yourself. Circumstances prevented her from getting it. The worst of that wasn't the mother's unsatisfied craving but that the daughter was born with a coffee-bean mark on her wrist. Another sports a liver-colored birthmark. That should have taught papa not to bring home the bacon when all mother really wanted was a good chunk of sautéed liver.

The Italians have shown their efficiency in dealing with such situations. Most nationality groups profess the theory that a scare will mark the baby and many claim that the mark will appear on the baby wherever the mother's hands touch her own body at the time of the fright. They suggest that when a pregnant woman is frightened she should not put her hands to her face and risk marking the baby conspicuously in this manner, that she get into the habit of placing them automatically on the buttocks. After all, who cares if one's well covered posterior is decorated?

EACH SEGMENT of the process of childbirth is covered, logically or otherwise, by a mass of superstitions. They start with menstruation, and many are the old wives' cautions for this delicate period! Some claim that if a menstruating woman touches a plant it will curl up and die. Many women will still refrain from canning fruit at this time for fear the menstrual period will cause it to spoil. Some say that at this time one should not touch cold water. Others extend this to anything cold for fear of "freezing" the flow, and the bugaboo about bathing during menstruation is so widespread that one would almost think it has the sanction of the medical profession. One hairdresser advises her clients not to have permanents while menstruating since they don't "take" as well then. She may have a valid point. The endocrine changes may possibly alter the oil content of the scalp; but this is merely a guess. Some claim that intercourse with a menstruating woman makes the man sick and that if the union is fertile the child will be feebleminded.

A passage from Pliny reveals the lengthy ancestry of some of these ideas: "At the approach of a menstruating woman, must becomes sour, seeds become sterile, plants are parched, fruit drops from the trees. Her very glance will dim mirrors, blunt knives, kill bees, and cause brass and iron to emit an offensive odor."[1] Is it any wonder that women have developed unearthly concepts about this process when such items have been tossed at their ears for centuries?

Spontaneous abortions have been the subject of much controversy among the followers of folkways. There are those who say that such calamity falls only in the even months. Others swear by the odd month for the ill fate. Both forces battle with equally strong statistics—which allows us to conclude that there's nothing to any of it. One woman told the sad tale of a friend who aborted after and because of driving her car, and another who did so from treadling a sewing machine. Still other causes are believed to be extreme fright and nauseating smells such as that of wet paint.

To the moon, a somewhat mystical and magical object itself, has been attributed more power in the field of obstetrics than all the wisdom of the medical profession. Its unfailing twenty-nine-day cycle has been connected with the more failing twenty-eight-day cycle of catamenia since menstruation began. In fact, there was so much fervor upon the subject that two British doctors examined 10,416 women and found that menstruation occurred at all times of the month, regardless of the lunar cycle, and concluded that "there is no justification whatever for the association of the date of menstruation or its rhythm with the lunar phenomenon."[2] However, it takes more than a mere 10,416 examinations to convince the old wives. They will furthermore compute the expected date of confinement by moonlight and be prepared for the occasion on the day of the full moon, or if the occasion requires, the day of the new moon. An amazing number of these women seem to be right.

Many members of the Grace-New Haven

Community Hospital staff vaguely hold to this viewpoint. Some of the more scientifically minded ones will try to explain it on the ground of the effect of the gravitational changes connected with the moon. Others will point out how many more babies the nursery harbors month after month when the moon is full, a slightly convincing argument whose accuracy is doubted when others reverse it and merely say the moon is full because the nursery is doing capacity business—yet one quick look out the window or at the calendar squelches this theory cold.

Another mystical concept is that about the premature infant. Many say that the seven-month baby is much more likely to live than the eight-month baby. This fallacy dates back to the time of Hippocrates and continues today, but statistics refute the belief and base it merely on the mysterious power which humanity has given the number seven.

CONCEPTION has its own collection of superstitions. Ideas about the result of alcoholism deeply penetrate this field. Many accept as a well known fact the statement that if the father is intoxicated at the time of conception the offspring will be feebleminded. Perhaps the intoxicated father is the first to jump to this explanation of his child's mentality. It is more painless than the theory of hereditary traits.

The wideness of the belief that conception is impossible while a previous baby is still nursing is shown by the unhappy mothers of one-year-olds who come to clinic bemoaning their coming child. The doctors say conception at this time is less likely, but woe be unto those who rely upon it as a contraceptive measure! Someone once started the story that a child's chance of becoming a leader increases if he was conceived in a period of sunspots and foul weather, but as yet no such period has brought forth a crop of congressmen and corporation directors. One of the biggest fish stories concerning conception was a woman's effort to prove the legitimacy of her baby on the ground that the father ate fish on the night the baby was conceived and that the water in which she bathed the baby always smelled fishy;[3] but then, so did her story.

After conception comes the big question, "Is it a boy or a girl?" Folklore here is in its glory. Even if your dignity demands disbelief, follow along with it; you have a fifty percent chance of being right. The methods are endless, but there is little controversy over them. For instance, if little boys take to you more than little girls do when you're pregnant, fear not; yours will be a girl. If it kicks you a lot and makes you uncomfortable it will be a girl too. Girls have that sadistic habit, some say. Along the same line, girls cause more morning sickness, though some say that this attribute really belongs to boys. Girls are lazy as well as disagreeable. If your baby is a week late, put away all of those blue ribbons and bows.

Women's vanity too enters the picture, and all because of long hair. Lots of heartburn means lots of hair. Some say it means a lot of red hair. It follows that since girls are supposed to have more hair we might just as well admit that a lot of heartburn means it will be a girl. Even the worst misogynist must put a little stock in the jingle: Sugar and spice and all things nice; that's what little girls are made of. Then isn't it perfectly obvious that if you crave sweets during pregnancy you're going to have a girl, and if you crave pickles or sauerkraut or lemonade you should get ready for a boy?

Male fetuses have their bad habits too. It's said that if you go into false labor you can expect a boy. That's because all males suffer from that awful inability to accept responsibility and some show it sooner than others. If the baby is conceived late in the fertile period blame it on women's laziness. If it is conceived early it will be a boy, because this supposedly takes more strength and effort. Many have tried to prove that if the fetal heartbeat is fast the baby is a boy, but just as many have been frustrated in their attempts. Others say that a boy is carried low, a girl high; a boy is carried to a point and a girl all around; that more pain or kicking on the right indicates a boy and more on the left is a sure sign of a girl. Or if you prefer the mystic you can try this one: Tie your own wedding band—no substitutions; obviously this would exclude all unmarried

mothers—to a strand of your own hair. Hold this firmly over your head. If the ring swings in a circle you'll have a girl. If it swings straight you'll have a boy.

Or if you prefer to be more subtle when trying to find out about a friend just have her sit on the floor and watch her get up. If she uses her right hand to assist herself she'll have a boy. If she uses her left tell her to prepare for a daughter. If she won't get up without help you can try this one: Watch how she holds out her hand. If it's palm down she'll have a boy. If it's palm up she'll have a girl. It is amazing to notice that throughout these superstitions the right is consistently connected with boys and the left side with girls. This may be because of the predominance of the right (righthanded people and our catering to them) and the associated feeling that this predominance belongs to the male sex.

THE FEAR of having imperfect babies and the desire to produce the best, prettiest, and brightest baby possible have led to many practices, preventions, and precautions. The Italian tradition suggests drinking plenty of red wine to produce lots of red blood for the baby. It also says that one should not look at any kind of food on the table without tasting it, for fear the baby will be marked. One might suspect that this is a perfect rationalization for the traditionally large Italian appetite. The Czechs suggest rubbing bacon grease on the abdomen to protect the baby. Italians prefer olive oil. The basis of this idea probably is to lubricate the skin, whatever the nationality. Practically every group advises listening to good music to produce a musically talented child. Some suggest the theater to develop his good taste.

The topic of birthmarks has been well taken care of by superstition. Some theories have already been mentioned. The idea of the baby's possessing a strawberry mark if the mother sees a fire springs from the idea that fright of any kind brings on such markings. One mother tells how during her mother's first pregnancy she saw a child hit in the face. This caused the child's nose to bleed and the woman's hair to stand on end. Instinctively she rubbed her own nose and wasn't surprised when her baby was born with a bright red marking in the same place.

The connection between birthmarks and cravings has already been noted. Longing for strawberries is quite naturally connected with "strawberry marks." This idea widens into the belief that unfulfilled craving for any fruit will result in a birthmark the shape of that fruit. Some say cravings will cause the baby to be born minus a vital organ. Whether he merely wanted to please his wife or whether he feared serious consequences is unknown but it is interesting to recall that Aly Khan sent a great distance for strawberries out of season when his wife Rita Hayworth developed a yen for them during her pregnancy.

Other deformities are equally well explained. If you swim during your pregnancy don't be surprised if you produce a hydrocephalic. Crossing the legs when sitting may be bad for your circulatory system from the medical standpoint, but the old wives have a more severe attitude about it. Don't do it; it will choke your baby. Similarly, sitting on your foot will cause the baby to have a club foot. A recent Italian immigrant said that at home people believe if you crave spaghetti during your pregnancy and don't eat some the baby will be born with the cord around his neck. Also, many mothers think that hanging clothes on the clothesline causes the same thing. Maybe this was concocted by someone who was too lazy to do the washing. Others think that any kind of reaching is bad, though this, like the spaghetti rumor, is unfounded. Wearing black or going to a wake during pregnancy is supposed to produce a sickly baby. Letting a young woman be godmother invites stillbirth. Choose an older woman.

Someone should be congratulated on the up-to-the-minuteness of some of the superstitions. From the dim past comes the idea that it is indeed bad to gaze upon snakes and toads during pregnancy. Your baby is sure to resemble them. It is even worse to look at ugly people or cripples for fear of what might happen. The famous Siamese twins were not allowed to appear in public because the reigning monarch believed the sight of them would have a bad effect on all pregnant women. Later the French government refused

to allow them entrance into France for the same reason.[4] Today's variation states that one should limit one's selection of television shows because of the effect they may have. Stay away from murder stories and the like during pregnancy.

FOLKLORE HAS done much to further anatomical and physiological misconceptions. "A tooth for every child" is a well known proverb. Now medicine not only denies this but is beginning to think that calcium once deposited remains in adult teeth, so that though low milk consumption will affect a mother adversely at many times, it will not affect her teeth; and with modern dentistry what it is there is no excuse whatever for this idea being filed anywhere but in the wastebasket. Some believe that green salad in pregnancy causes the baby's bowel movements to be green, although of course the medical world looks down its nose at this idea.

Heartburn and a choky throat are believed to cause the baby to have thick hair. A basis for many legends and superstitions is the belief that the baby who cries from the womb will be an exceptional child. We know that since vocal sounds are caused by the passage of air through the larynx and that in utero the baby is enclosed in a gasless, fluid-filled sac this is entirely impossible. What might have been heard in some cases was gas in the intestinal tract.

With delivery comes a similar group of delightful absurdities. The caul as a symbol of luck for the newborn is universally accepted among the old wives. The idea of putting a knife under the bed to cut the pain varies in some places to putting a hatchet under the bed to cut the hemorrhage. This is possibly connected with the idea of putting a piece of metal at the back of the neck to stop a nosebleed. In some sections the placenta must be destroyed in order to assure the baby's safety.

After delivery, with or without the benefit of the old wives' lore, one would expect that these petticoat witch doctors would sit back and breath a sigh of satisfaction, but no such luck! Their field then changes from obstetrics to pediatrics, with information about witches' milk present in the babies' breasts, babies smothering because of being allowed to sleep on their stomachs, and so on. But that is another volume.

From this study one can draw several conclusions. People used to be very superstitious. Some people still are, and rather than delving into the past for their superstitions they easily adapt them to the times. Those who say they are not superstitious are often misled and those who are not misled should at least enjoy the fun of folklore. Superstitions are as widespread as pregnancy itself. A Latvian woman summed up the universality of folklore perfectly in a letter comparing superstitions from her country with those prevalent in the United States, "I am sorry I can be of no help to you. I cannot think of any other superstitions. The ones at home are all the same as the ones you have told me." Though the Czechs may not be concerned with spaghetti eating, or the Eskimos with strawberries, it is safe to assume that the essence of the world's beliefs is the same. So long live science, and may its good works spread; but similarly may our folklore thrive and our understanding of it develop so that women may realize its lack of significance but continue to let it brighten their 280 days!

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Process Recording in Public Health Nursing

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CALIFORNIA'S second Asilomar workshop on public health nursing field instruction brought forth some thoughtful and challenging questions and had some interesting follow-up activities. One group of experienced public health nurses at the workshop suggested that established methods of supervision should be examined. The group asked particularly: Are there serious limitations to the supervised home visit which may create barriers to the students' growth?

This group of nurses was interested in the possible values of process recording to improve relationships between the student and her adviser or supervisor and to contribute more to student growth than the supervised home visit.

Process recording, as used in social casework, refers to a written account or recording of the interaction or process within an interview. As used by the workshop group it was defined as a verbatim account of a visit for the purpose of bringing out the interplay between the nurse and the patient in relation to the objectives of the visit. This account should be written by the nurse immediately following the visit and later discussed and analyzed in conferences with her adviser or supervisor. A summary of the visit, not a verbatim account, would be written by the student as usual on the agency record. The group saw the advantages of process recording as (1) it would place more responsibility on the student for evaluation of her work (2) it would help the student to develop a tool for continuous evaluation of her growth, a tool which would guide her in more thoughtful consideration of her interviewing technics (3) it would lead to improved records, which in turn would improve continuity of service to patients and families.

One obvious disadvantage of process recording as a supervisory method is that it does not allow for observation of the total situation in the home, particularly for evaluation of technical skills. The success of a nurse, however, depends not only upon technical skills but upon her teaching ability and the feelings that are engendered between her and the patient. More and more it is realized that interpersonal relations are important to success in nursing. The factors which are basic to good interpersonal relations are also basic to good interviewing. In every public health nursing visit, no matter what the purpose of the visit is, there is some interviewing by the nurse. This purposeful conversation may be to obtain information, to instruct or to guide the patient to better understanding and participation in planning how to meet his individual health needs.

Too often the nurse teaches without an adequate knowledge of the actual needs of the patient and his family. Frequently she is so busy accomplishing the planned purpose of the visit that she fails to listen to what the patient is saying or trying to say or to interpret how he may feel about a specific problem. Ought nurses restrain their well motivated impulse to explain and interpret until they have a more adequate knowledge of the patient, the family, and the situation?

Process recording has been found to be of value in social work, particularly for certain interviews, to direct attention to attitudes,

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behavior, and motivation. Although thus far we have used this method with only two groups of registered nurse field students of the University of California, Los Angeles, we believe it may have a definite contribution to supervision in this field. Process recording as a method of supervision in the university field was started in one agency, the Los Angeles County Health Department, as we were aware of the need for guidance in this procedure by others more familiar with its use. There is a Bureau of Medical Social Service in this agency, with a medical social caseworker in each of the thirteen district health centers. The members of this bureau have been of inestimable value in helping us to apply process recording to the objectives of public health nursing supervision.

THE UNIVERSITY representative discussed the project with the student advisers and others concerned with the student program. There was enthusiastic acceptance of the experiment. Since time was an important factor the advisers and supervisors received their preparation for participation in process recording concurrently. As the students in the first group were also unprepared for this experience when they came to the agency the explanation of process recording was undertaken by the agency personnel. Preparation for this, however, is now incorporated in the first required professional course, Public Health Nursing, and application is made in other courses.

In this County Health Department responsibility for the more formal group preparation of the advisers for their delegated supervisory activities with students is assigned to the educational director. Therefore, the director of medical social service helped the educational director to a better understanding of process recording as a supervisory method. Supervisors and student advisers were prepared in group conferences with the educational director and also individually in the district health centers. The need for this assistance varied in the local districts as some supervisors and advisers had experience with process recording.

At the conferences of the educational director with the supervisors and advisers, the purpose and procedure in writing a process record were discussed and recordings were analyzed and evaluated. The importance of a nonjudgmental attitude in such evaluations was stressed. As the purpose of the recording is to help the student to see herself—as she functions in service to the patient or family—through the eyes of her supervisor or student adviser, it was recommended that the student be asked to give a complete picture of the interplay between the patient and herself in order to reflect as accurately as possible what took place—to describe not only how the patient responded but also her own feelings and reactions, as her adviser would like to see her as well as the family in this situation. It was also suggested that recordings include not only a description of the visit but also the tentative plan and a brief summary explaining the situation, problems, future plans, and the nurse's feeling about the visit, which would include areas in which she felt satisfaction with her performance, as well as those in which she felt uncomfortable.

In most district health centers the student adviser helped the student to understand how process recording is meaningful as a method of supervision. In a few districts the social caseworker participated in this explanation. As students expressed a desire to try process recording, they were asked to write a report of at least one visit describing what happened during the visit, quoting as much of the pertinent conversation as they could remember.

The recording was usually reviewed by the supervisor, the student adviser, and the social caseworker. The recording was then discussed with the student by her adviser and the caseworker, although in some districts where the supervisor and adviser had had previous experience in process recording the caseworker did not participate. The adviser called attention to the strengths of the visit, and with the student assuming the initiative, raised questions about approach, teaching method and content, application of learning principles, and phrasing of questions.

The medical social worker in some districts had one interview with the student on her process recording. In this interview she tried

to bring out the interaction that went on between patient and nurse in terms of promoting a better understanding of the kind of person the patient was, illustrating with examples from the nurse's recording of the visit. Limited by this one interview, it was not feasible or possible to help the nurse to analyze, recognize, and understand her own feelings as reflected by the responses obtained during the visit. The worker tried to help the nurse to understand why the patient behaved as he did, bringing out the pressures and handicaps present in this particular situation.

At present the recording of the nurse differs from the usual process recording of the social caseworker, in that the content of the nurse's interview is related to a different purpose from that of the caseworker. For example, the social caseworker when doing a social service interview may see the need not to reassure the patient but to help him to use his anxiety in constructive ways. This often may take more than one interview. In this stage of the development the nurse is primarily telling the story of her visit. The following recording reflects such things as the nurse's manner of approach, her security in working with strangers, and her basic liking for people.

Excerpts from a 12-page process recording

Introduction. Having observed the patient and his sister in chest clinic two days ago, I approached their home with confidence for I knew they had been prepared for the visit and that their attitude indicated a desire to do that which was best for all concerned.

The twenty-one-year-old patient is a tall, lanky lad about five feet eleven inches tall, weight 145 pounds, with an auburn "butch" haircut and a slightly ruddy complexion. He came to the Health Department with a diagnosis of pulmonary tuberculosis, minimal type, as a result of a chest plate taken by the draft board for selective service. A culture of sputum was reported negative.

There was a request for a nurse's follow-up investigation for the following purposes: (1) to complete form VR 42, of a case of TB or contacts (2) to invite adult members of family to participate in chest x-ray mobile unit (3) to deliver appointments for all members of the family to have Mantoux tests on March 17 at 9:00 a.m. (4) to check isolation technic in the home and see what arrangements have been made about the patient's home care until placement can be made. (Until the clinic interview he had been sharing a room with his two nephews, ages six and eight; the boys occupied the lower portion of a bunk bed and the patient the upper portion.)

The Visit. I rang the bell at the door of a green asphalt-siding-covered home with a neatly cut front lawn and a clean front porch. When the door was opened by the patient's sister, a short, thirty-year-old auburn-haired woman, I introduced myself as Miss C, public health nurse from the Health Department. She welcomed me with evident relief, saying that she and the patient had been expecting me. The patient, an amiable, friendly young man, was hunched forward on the living-room overstuffed sofa. He wore a freshly laundered shirt and neat blue trousers. On his feet were socks and warm, new-looking felt slippers.

By way of greeting the patient chided himself with "get to bed, John." I remarked that we had some papers to fill out, and the sister invited me to do my writing at the dining-room table. I seated myself at one end and the patient sat at the opposite side, about four or five feet away. To my right, between us, the patient's sister seated herself.

The patient immediately began to reel off his worry and concern because he had been in this community for only three months and there had been discussion with medical social service about sending him back to his legal residence in Pennsylvania. This disturbs him a great deal, as he feels that his parents cannot afford the expense of his hospitalization. His sister too echoed his concern, with the hope that placement could be made in this area. I tried to reassure them that everything was being done to make a satisfactory arrangement for him, especially because of the two young children in the home. They seemed relieved.

I explained that the reason for obtaining the list of contacts is that they might all have the opportunity to have chest x-rays and skin tests. The patient laughed self consciously and remarked, "All of those people will be bothered on my account." I hastened to assure him that he was doing them a service. In fact, another reason for this visit was to be sure that all the adult members of the family took advantage of the mobile x-ray unit, which would be parked outside the health center on March 18 between 12:30 and 6:00 p.m.

Getting back to the list of contacts, I asked the patient whether he was engaged or had any close girl friends or boy friends whom he would like

to mention. The patient snickered with shy embarrassment and looked away, saying, "No—." Then he looked straight at me and said, "Well, not here, anyway." "Well, how about at home?" I countered. The patient hemmed and hawed and seemed so embarrassed that I suggested he think about it awhile, while we list the local contacts. When the list of contacts seemed complete we returned to those in Pennsylvania and he added the name of a forty-three-year-old fellow worker with whom he'd spent a great deal of time, frequently eating with him. "I'll bet he won't be bothered with a chest plate," the patient remarked. I let a pause follow; then I asked again, "No girls?" "No, I guess not," he answered uneasily, "I don't remember any addresses."

Seeking to change the subject the patient asked, "Is it all right if I go out for a walk every day? I must have my constitutional." He mentioned a walk he had taken that day of at least two miles. I tried to tell him as gently as I could that this was too much exertion for him, that he should try and think of all the things he always thought he would like to do, and then try to enjoy those things he could do within the confines of his own room.

Then I requested that I be shown the patient's sleeping accommodations. A small bedroom contained bunk beds. I was told that the patient occupied the upper bed, and the two nephews slept in the lower bed. Next to the children's room I was shown the "back porch," where a few odd pieces of furniture and other odds and ends were stored.

"This room might be a perfect solution," I said. "There're no rug or curtains to pick up dust, and if we could just get some of these things moved out we might have a suitable place for you to spend your time. You might bring a radio out here, and fix it up to suit your needs and comforts. Wouldn't you like a room of your own?" I smiled convincingly at the patient but he was feeling rather skeptical. Then the sister suggested that the gas stove in the adjoining room might be brought in to heat the porch. The patient was a little leery of the arrangement, saying that he thought it would be too cold. I asked him whether he didn't think he could wear a warm sweater and keep himself comfortable with warm bedding. His sister thought this might be arranged.

I remarked that the use of the porch was only a suggestion, not an order, but it *was* imperative that the patient no longer occupy the same room with the children, and that they be kept away from the patient. I added that should the porch be used, a piece of furniture might be placed in the doorway to remind the children that they were not to enter.

The patient's sister looked at him sadly and remarked how much the children loved to wrestle with their uncle. I agreed that it was difficult to restrain one's self from the pleasure of playing with the youngsters, but that these plans were for their benefit.

The conversation then turned to isolation technics and we discussed keeping the patient's dishes separate, boiling them for five minutes, then washing them in hot soapy water. We also talked about burning leftover food, keeping soiled tissues in paper bag and burning, and using three folds of tissues in front of the mouth when talking, laughing, coughing, or expectorating. The sister was also reminded about washing the patient's linens and clothing in the washing machine all by themselves.

Two pieces of tuberculosis literature were left with the patient, whose interest was so great he began reading while I talked with his sister.

As we neared the front door the sister reiterated that if this were her own home she would not feel so strained about the situation, but since this house belonged to her aunt and uncle, from whom her little family were renting, she did not feel free to shift the furniture around. I agreed that it was a difficult situation and that I would be back to see them again.

At the door the pair thanked me and said goodbye, promising to use their influence to bring the family for chest plates and Mantoux tests.

Evaluation. This visit was approximately one hour long. It is possible that I may have overwhelmed the patient with the prohibitiveness of my teachings, or with the quantity of information. Some of the information I offered may not have been as vital as some which I did not mention, such as the following:

(1) Liquids which the patient leaves in his glass or cup should be discarded in the toilet bowl *only*.

(2) In the event the family arranges for someone else to occupy the bed in which the patient has been sleeping the mattress, pillow, and linens must be exposed to direct sunshine for five hours on each side. Also, the bedstead and springs should be wiped with a cloth wrung out of a disinfecting solution.

On my next visit I shall try to bring more tuberculosis literature and information about diet to help the sister in cooking for the family. I am wondering whether I shouldn't have asked for names of possible contacts with whom he worked locally, inasmuch as he didn't mention any.

Appraisal of method

After process recording had been used by the first group of students a verbal appraisal was made of this experience. Almost all of the students who had participated were enthusiastic about its advantages as one method of guidance. Supervisors, advisers, and students quite generally thought it had been an effective tool in improving the student's performance, particularly in interviewing and self evaluation. The chief disadvantage appeared to be the timeconsuming aspects of the assignment for the student. Despite this they suggested that future students write three process records, because repeated performance of this procedure would greatly increase its value to them.

In November 1951 a written appraisal of process recording was requested of the second group of students and the advisers who had participated in this method of supervision. To guide them in writing this two groups of questions were formulated by the authors: one group for students and one for advisers.

Advisers Opinions. The advisers were asked to express their opinions regarding the effectiveness of process recording as a supervisory method, particularly in comparison with the supervised house visit. The advantages expressed most frequently were its motivation for self evaluation; its stimulation for student's initiative and objectivity in discussing the visit and her performance. Both the student and adviser were more comfortable in analyzing the student's performance described on the record than in analyzing her performance as observed in the supervised home visit. They thought the elimination of the third person in the home visit allowed for a more natural situation.

The two main objections to this procedure were the time involved for the student in writing up the visit and the inability to observe the complete situation, particularly skills, tone of voice, and mannerisms of student.

The advisers think this is an excellent method with many advantages but believe it does not completely replace the supervised home visit.

Students' Opinions. Students were asked how process recording affected their performance in applying principles of learning; questioning; planning teaching content; selecting pertinent information for the agency record; and assuming initiative in self evaluation. In answer to these questions on performance the students described less favorable aspects of visits which had been revealed in the first process record and indicated frequently how this knowledge of their behavior favorably affected subsequent performance.

The majority of students indicated that process recording had been of specific value in helping them to enrich the teaching content of visits and apply principles of learning, particularly in motivating and in meeting the felt needs and interests of patients; improve their approach to patients and analyze and correct specific weakness in interviewing, such as doing most of the talking, asking too many direct questions, or questions which could have antagonized; select information for the agency record which might otherwise have not seemed important.

The outstanding value of process recording to all students was its motivation for continuous self evaluation. As one student expressed it: "Seeing in black and white the mistakes that one can make gives a greater awareness of oneself in action and thus the awareness of the need for continuous self evaluation. The habit of mentally reviewing each visit has resulted from the experience in process recording, and is a tool for self evaluation, the most valuable outcome of this experience for me."

Students were also asked their opinions of the advantages and disadvantages of process recording and the supervised home visit as methods of supervision.

The advantages of process recording mentioned most frequently were that it eliminated the disadvantage of the presence of a third person, and did not disturb nurse-patient relationships; the visit was less structured; it was more effective than the supervised home visit in stimulating student self analysis, and provided students with a tool for continuous self evaluation. Advantages stated less frequently were that it put a minimum of strain on student adviser relationships and the written evidence helped students to be objective about their performance and to accept suggestions.

The important advantages of the supervised home visit were the opportunities provided for the adviser to observe the student's nursing technics and behavior and the attitudes and feelings of which the student might not have been aware, or might have misinterpreted.

The chief disadvantage of process recording was the timeconsuming aspects of the procedure. Some students stated that relying on the memory of the student provided for a possible margin of error and possibly for unconscious censoring of the visit in the recording

Disadvantages of the supervised home visit mentioned most frequently were that the presence of a third person made the student more tense and lessened her ability to concentrate on the needs of the patient, and some students tended to direct questions or problems to the adviser.

Despite the disadvantages found in process recording and in the supervised home visits most of the students indicated that each method had played an important part in their development during public health nursing field experience and recommended that both methods of supervision be continued.

This article is a progress report. Questions in the first part of this paper cannot be answered yet. To date the advantages of process recording as envisioned by the workshop group have been demonstrated. Though timeconsuming and subject to error its use is highly desirable and practicable in public health nursing field experience where students are not responsible for the service load of an agency. Present plans are to continue using and evaluating process recording in the field program. Supervised home visits will also be used, as there are sufficient advantages in this method of supervision to justify its use with process recording unless further study brings out evidence to the contrary.

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Contact Lenses

ELIZABETH F. CONSTANTINE, M.D.

RECENTLY there has been a widely increased interest in the subject of contact lenses, not only among members of the medical and nursing professions but also among the general public. For this reason it seems pertinent to review the present state of knowledge in this field.

Contrary to popular opinion, the contact lens is not a new concept. In 1827 Herschel, an English physicist, suggested that such a device might be used as a protective covering for the eyeball in patients with diseased lids. But it was not until 1887 that the first lens was actually made, when Fick of Zurich requested the Zeiss Company to grind a glass lens for him, which he successfully used to improve vision in a case of irregular astigmatism. Two years later it was found that this lens had not been ground, but blown. About the same time August Muller, a glassblower of the Muller firm at Wiesbaden, fashioned a lens for a patient with cancer of the lids of his only eye and consequent keratitis. It was highly successful as a protective measure, and led to many more requests for lenses.

This was the beginning of the development of the Muller lens, which is a blown lens made of the same glass as artificial eyes. It consists of a clear corneal segment and an opaque scleral portion, on which blood vessels are painted, exactly as in an artificial eye. Unfortunately, the glass is too brittle to stand grinding, and the corneal segment cannot therefore be made optically perfect; several investigators have found that there is almost always a small astigmatic error in them, and not infrequently a large one. No two lenses being alike, it was a long and tedious job to find one which would fit a patient's sclera and also produce the desired optical effect, and success was largely a matter of luck. Also, the life of these lenses was limited to about two years, as in artificial eyes.

In 1892 Sulzer, acting on Fick's theory, inaugurated ground lenses for the treatment of keratoconus and irregular astigmatism. This led to the manufacture of the Zeiss ground lens. The original ones were made with a scleral radius of 12mm, a corneal radius of 8mm, and an overall diameter of 20mm. In the first quarter of this century only a few minor changes were made in this lens, and it was difficult or impossible to obtain a comfortable fit. They were poorly tolerated in most cases, and it was generally agreed that the Muller blown lens was, in spite of the hit-or-miss method of fitting, much the more satisfactory of the two types.

It was not until after 1930 that the Zeiss stock lens was developed. This was the contact lens which marked the beginning of interest to the general public. The improvement lay in more accurate grinding, so that lenses were made available in a number of different stock sizes, for both the scleral and corneal portions. Thus a much better fit could be obtained, and a wider range of refractive errors corrected.

In 1934 the Muller firm announced a new type of blown lens, with a corneal segment which could be secondarily ground and thus corrected to the patient's prescription. When a satisfactory fit could be found these lenses were worn with greater comfort than the Zeiss ground lenses. The reason for this was thought to be that the irregular, blown scleral rim, when it fitted, conformed so much better to the contour of the sclera, which is always somewhat irregular, than did the regular scleral portion of the ground lens.

This lent impetus to the idea of making a mold of the anterior segment of the eye, which

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had been considered for some time, but no suitable material had been found. In 1937, Dallos published in England the results of his experiments with a substance known as negocoll. Soon afterwards a New York optician named Obrig, using the same material, devised a simplified technic of molding which produced quite accurate castings. Since that time other improved materials have been developed and refinements made in the technic, and the conventional contact lens is now always made from casts taken from molds.

Until 1934 all contact lenses were made in Germany. That year a New York firm began manufacturing lenses of the Muller type, but the Zeiss lens, made in Germany, remained the most widely used. Then the development of plastics such as lucite and plexiglass spurred American manufacturers to experiment with the new materials, and with the advent of World War II German lenses of course became unavailable. Soon there were several firms in this country making various types of plastic lenses, of both the stock and molded varieties.

Plastic lenses have several advantages over glass ones, the most important being that they are unbreakable. They are also much lighter in weight and while they scratch easily minor scratches do not damage them, as their surfaces are always wet when in use, and deep gouges can be avoided with reasonable care. Plastic does not "wet"—that is, take water evenly over its surface as does glass—without the use of a wetting agent, so these lenses must be cleaned with such a solution and rinsed with water before use.

IN 1948 a new type of contact lens was introduced by an optician named Tuohy in Los Angeles. He called it a corneal lens, as it consists of a corneal portion only, with no scleral flange. It is made in diameters of less than 12mm, and rests entirely within the limbus except on motion of the eye, when it overrides it slightly. It is held on the cornea by capillary attraction and the surface tension of the tear film, which fills the very narrow space between the back of the lens and the cornea. No accessory fluid is necessary, as it utilizes the normally secreted lacrimal fluid. This is a great physiologic advantage over the conventional type of contact lens, which requires the use of an artificial solution to fill the much larger space between the lens and the eye. Although many varied types of solution have been tried, none has been found to be entirely satisfactory, and it is now generally thought that no artificial solution ever will be, as changes take place in its chemical composition after several hours of wearing. These changes result in absorption by the cornea of some of the fluid, with consequent corneal edema and haziness of vision. The corneal lens, by allowing circulation of normal tears behind it, does away with this difficulty.

There are other advantages: it is more easily fitted, involving no molding; most people find it easier to insert and remove; and cosmetically it is almost perfect, being virtually indiscernible. Perhaps its greatest advantage, however, is that it is a stock lens, so that any given size can potentially be used on different individuals. This means that a patient may try out a pair of lenses and if unable to wear them, return them to the laboratory. The conventional contact lens, being molded for the irregular sclera of the individual, cannot be used for anyone else. This makes trial of the corneal lenses less of a financial gamble.

However, there are certain definite disadvantages to the corneal lens. It can be dislodged from the cornea by excessive exertion or contortions of the lids, and is therefore not recommended for active sports, particularly swimming. It may "pop out" of the eye during a violent attack of coughing or sneezing, and it is so small that it may be rather easily lost. Also, it produces a certain amount of corneal irritation with resultant stinging, burning, or tearing of the eye. In patients who wear this type of lens successfully, this irritation is minimal and decreases with repeated use, so that eventually they are hardly aware of their lenses at all and wear them throughout their waking hours. But there are others who never develop this tolerance and find that their maximum wearing time is limited to one to three hours.

Very recently another modification of the contact lens was made by Salvatori, a New York optician. It seems to combine some of

the best features of the conventional contact lens and the corneal lens. It has a large molded scleral flange and a corneal segment which is not raised as much as the conventional type, but fitted very close to the cornea, just far enough above it to avoid contact. Access of the tears to the space between the lens and the cornea is provided by a channel cut in the scleral flange below the lower lid, so that again the lacrimal fluid is used instead of an artificial solution. He calls this lens the Obrig Lacrilens, and although it has not been extensively used yet, experience at this writing seems favorable. Its greatest disadvantage is the difficult and tedious fitting process, which involves a higher cost. Because the lenses are made from molds, they can be used only for the given individual.

THE FACTORS which determine the wearing time of a given patient with any type of contact lens are not fully known. With the conventional type the fitting is a delicate procedure and must be perfected before comfort is achieved. The type of accessory solution may have some influence, although it is slight. With the corneal lens a good fit is more easily arrived at and actually seems to make less difference. The main factor is undoubtedly the desire and determination of the patient to learn to wear the lenses. Incentive is therefore of great importance. If the patient can get along at all without glasses, or sees well with spectacles and does not mind wearing them for ordinary use, he is not apt to do well with contacts. He will usually decide after a trial period that they are "just too much trouble."

There are various indications for the use of contact lenses. First and foremost, there are a number of conditions in which this is frequently the only means of securing good or even fair vision. Among these are conical cornea, irregular or cicatricial astigmatism, aphakia with high astigmatism, some cases with corneal grafts, and very high refractive errors. Such cases usually are the most successful users.

Secondly, a contact lens may be of value as a protection for the cornea. Such conditions include vernal catarrh, trachoma, trichiasis, entropion, and exposure keratitis. It may also be used in certain occupations to protect the eye from chemical burns. Duke-Elder used it to obtain relief in cases of mustard gas keratoconjunctivitis, in which the corneal lesions have a habit of breaking down intermittently.

Contact lenses have been used by surgeons in applying mucous membrane grafts to the lower cul-de-sac, and also to prevent the formation of adhesions in this region. They have been reported to check nystagmus while being worn, and when tinted to be helpful in albinism.

There are quite a few occupations and recreations where contact lenses have proved their worth because of the cosmetic improvement over spectacle lenses, the increased field of vision, the fact that they do not fog, and their greater safety factor. Among these are acting, lecturing, driving, flying, sailing, swimming, deep-sea diving, skiing, and football. A more recent one is television, where actors find them vastly superior because they eliminate the distracting glare caused by spectacle lenses.

Because of the smaller image produced with a contact lens in an aphakic eye, binocular vision may sometimes be obtained in cases of monocular aphakia.

Special modifications of the contact glass are used in certain technics of examining the eye, and in combination with spectacles as a type of telescopic lens.

However, the largest demand for contact glasses is for purely cosmetic reasons. Young girls and women who will not wear spectacles because they are self conscious about them can be given not only good vision but self assurance by the use of such lenses.

A recurrent question is the possibility of damage to the eyes by the continued use of contact lenses. There are ophthalmologists who advise against them on this ground, but I can find no report in the literature of a case where permanent damage has been done, and there are a number of cases recorded of constant wearers who have showed no ill effects over periods of up to ten years.

It is possible to injure the eye by forceful insertion or manipulation of a lens or by

scratching the eye with a fingernail. Such abrasions usually heal readily and can be avoided by careful instruction and handling. But for this reason I believe that highly nervous or apprehensive individuals and young children are not good candidates for contact lenses. As a rule, I do not like to fit them for a child under sixteen, depending of course on the maturity of the child. In older people there is the difficulty of obtaining good vision for reading; as bifocals cannot be incorporated in contact lenses a pair of reading glasses must be worn over the lenses for close work.

The perfect contact lens has not yet been developed and perhaps never will be, but forward strides are constantly being made. Their value, while limited, is beyond doubt in some cases and even vital in a certain few.

Lead Poisoning in Young Children
The Role of the Public Health Nurse

MARGARET GALBREATH, R.N.

FROM OUR experience in participating in a program of lead poisoning in young children in Baltimore we think this health problem must present a challenge to public health nurses in other localities also.

Lead poisoning is a cumulative poisoning caused by the ingestion of lead into the body. It is of particular significance in children as it may cause death or encephalitis; in many cases there is permanent brain damage.

The Baltimore City Health Department began to study instances of lead poisoning in children in 1931. Since then 350 cases have been reported. The ratio of cases and deaths between white and Negro children was 1 to 2; 107 cases and 31 deaths among white children and 243 cases and 60 deaths among Negro children. About 58 percent of the children, 204, were in the twelve- to twenty-four-month age group—the teething age. In 1951, when lead poisoning was the third ranking cause of death in the one- to four-year-age group in Baltimore, 77 cases were reported. Nine of the children died and 22 showed evidence of encephalitis. Only pneumonia and tuberculosis killed more children in that age group that year.

The Health Department's plan of attack has developed along two lines: (1) home investigation and law enforcement (2) education and publicity, stressing prevention. For some years home visits have been made to all reported cases. First the investigation was carried out by the sanitarian and later by the public health nurse assigned to the special program. The purpose of the investigation was to find out the child's condition and also to ascertain the likely source of the material ingested. The ingestion of lead pigment paint has been found to be the causative agent. It is on this premise—that without lead there would be no lead poisoning—that the present program of the Health Department is based.

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Under the Baltimore Ordinance on the Hygiene of Housing the presence of paint containing lead pigment is interpreted as being a health hazard, and the elimination of the source of danger, when not done willingly, can be enforced. In June 1951 the Health Department adopted a new regulation specifying that the painting of interior surfaces must be done with paint free of lead pigment. Of course, the effects of this regulation will not be immediate but its enforcement should do much in helping to cut down on the occurrence of lead poisoning in children. Lead poisoning is chiefly a disease of the slums where bad housing conditions are prevalent.

Education and publicity go hand in hand in emphasizing prevention. Newspaper releases and radio shows have been used freely. As there is a sudden marked rise in incidence during the summer months publicity is increased just prior to and during the summer season. The Health Department has prepared a pamphlet on the subject which is widely distributed in well baby clinics and through other channels. New staff are instructed in the importance of this preventive program. Sanitarians assigned to housing and rodent control are particularly alert to the dangers of flaking paint on their inspections and to the need to have such conditions corrected. Lead poisoning in children has been stressed in the educational programs of the public health nursing staff and affiliating student nurses. Talks are given to interested community groups, with emphasis on the relation of housing to the incidence of the disease.

THE NURSE in a generalized public health nursing service has excellent opportunities for casefinding and preventive work in the area of lead poisoning. By observing the condition of a child in a well baby clinic or during a home visit and by inquiring into a possible history of paint chewing or eating, she can make a splendid contribution in cutting down the incidence of lead poisoning in young children. It is particularly important that a nurse consider the possibility of lead ingestion when a child shows some of the more common symptoms of lead poisoning such as pallor, irritability, vomiting, loss of appetite, and cramps, in addition to pica (craving for unnatural articles of food). As these symptoms are quite common in several childhood ailments the parent often does not associate them with lead poisoning. However, medical referral is always indicated when there is a history of paint chewing or eating.

It is natural for the toddler, who is the greatest victim of lead poisoning, to put everything into his mouth. He is at the stage when he is filled with curiosity and the desire to explore and some of his feelings are satisfied by chewing on objects indiscriminately. He seems to be particularly attracted to crib rails and accessible window sills. Parents must be given some understanding of this phase of child development so that they can give children the proper guidance and understand the importance of supervision of the child's activities.

On visits to the home where there are small children the public health nurse can well include instruction in the prevention of lead poisoning as part of her home safety supervision. She can help parents select suitable toys for children. Toy manufacturers have been most cooperative in providing safe painted toys. In homes where paint is flaking or has been chewed from surfaces and there is no way of determining lead content, removal of the paint from accessible areas and repainting with nonlead pigment paint should be stressed.

Lead poisoning in children can be completely eradicated only when parents are well informed of the dangers associated with children's ingesting the poisonous substance. The public health nurse as an effective disseminator of information can play a major role in the prevention of this needless maiming and killing of children.

For a more detailed account see Lead poisoning in young children, by Williams, Kaplan, Couchman, and Sayers. *Public Health Reports*, March 1952, v. 67, p. 230-236. This article contains an excellent bibliography.

Inservice Education: The Staff Public Health Nurse

This is the second article describing inservice education plans for various types of public health workers during reorganization in an official agency. The first article in the July issue gave the background and details of the plan in which the services of the Buffalo City Department of Health, the Lackawanna City Department of Health, and the Erie County Public Health Nursing Service were united.

RUTH EASLEY RIVES, R.N.

MANY IMPORTANT things happened in Erie County in 1947 preliminary to the organization of a generalized nursing service, and all were part of the reorganization pattern. One of the more important activities, as far as public health nursing was concerned, was conditioning of the staff to the generalized nursing service. The rural staff had for many years been functioning in a generalized nursing service although caseload analysis revealed a heavy list toward tuberculosis nursing service. This was not surprising inasmuch as the largest health problem in the area was tuberculosis. The urban staff had functioned as specialized groups entirely, serving the population as tuberculosis nurses, school nurses, and nurses for venereal disease control. This staffing was justifiable on the basis of need in each area in 1948, although the picture has changed somewhat since then.

Meetings held with the several staffs for interpretation of the generalized program revealed a detached interest in the joint program and a willingness to be shown the value of the generalized nursing service—although when it was interpreted as a "family health service" most of the staff nurses were convinced that they had been carrying such a service. However, after discussion they accepted the plan, that a complete family health service be set up on a demonstration basis. Representatives from each of their specialized groups were to participate in the demonstration, then report back to the several groups about the type of service, the differences between it and the specialized services, and the advantages of the program.

In August 1947 a group project was organized in the city of Buffalo in a section where the need for health services was very great. The area included those census tracts where the maternity mortality rate was highest, where the infant mortality rate was high, where the tuberculosis mortality rate was very high, and where venereal disease was most prevalent; in addition the housing was poor, the population transient to a certain extent, juvenile delinquency high, drug addiction prevalent, and the general socioeconomic status of the area low. We started this demonstration with fourteen staff public health nurses, one supervising nurse on loan from the New York State Department of Health, and two nurses who qualified for supervisory appointments on a provisional basis. The staff public health nurses were, for the most part, volunteers from the specialized services with a sprinkling of new staff. The population of this area was 44,000 and the ratio of staff nurses to population was about 1 to 3,200.

It was necessary during this time to consider the educational needs of the staff for functioning in this new program. This was accomplished in three steps: (1) careful study of the needs of the job at hand (2) determination of what knowledge and skills the staff should have to carry out the job (3) establish-

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ment of the most logical way of meeting these needs. This was a tremendous job and called for a tactful approach, for the staff nurses were loyal to their old programs and it required sympathetic and understanding interpretation to condition them to the values of the new.

The approach had to be individualized, as the needs and attitudes of no two staff were identical. Many saw the need to face their own problems and to arrive at their own decisions, although others staunchly defended the old pattern. Others were so interested that they were carried along on their own momentum and became so intensely involved that they would have seen the experiment through regardless of what it cost in time, effort, and energy!

ALL OF THE nurses assigned to the generalized nursing service had, with few exceptions, one year of university study in public health nursing. The few who did not have this preparation had qualified under the old regulations, which specified either that the nurse have one semester of work in an approved program of study in public health nursing plus experience in the field, or one year of experience in public health nursing under supervision. Because of such discrepancies in educational background it was essential to plan an educational program to meet the needs of the individuals in the group, rather than make a plan to meet the group needs.

The first few months moved along smoothly enough, as the reorganization of the Buffalo City Department of Health and the Erie County Public Health Nursing Service into one unit had not yet taken place. As we swung into the reorganization changes occurred rapidly, the old gave way to the new, and we had to make plans to meet special needs quickly. We believed that the use of lectures and demonstrations in this situation would be most effective. During the first year more than sixty different subjects were covered in our short order program, each session lasting from one to two hours. Of course this was a terrific schedule but we found it was necessary to keep to it in order to interpret new phases of old programs and to get information to the staff on interdepartmental policies, interagency relationships, and technics and procedures. The attitude of the nurses was splendid during this rather hectic period of change. They accepted and evaluated new ways and means and smoothly made shifts in their plans to conform.

One may wonder what was covered in these many orientation classes. We ourselves were rather surprised that we had included so many things. Among the subjects presented were nursing bag technic, for many had not previously used nursing bags; the home visit; use of community agencies, which covered many hours of instruction, and was participated in by representatives from local agencies; the maternity visit for antepartal and postpartal instruction; home delivery; demonstration of baby bath and how to make a formula; communicable disease visit, including demonstration of isolation technic; the technic of interviewing in tuberculosis and venereal disease; problems in venereal disease control; dental hygiene program; recording in the child health conference; care of cancer patients and the type of referral used in special hospitals for the care of cancer; review of personnel policies; nutrition; BCG vaccine; vision testing; demonstration of hot blanket pack for the poliomyelitis patient. All of these and many more subjects were included so that the staff could have pertinent information on the spot.

AT THE beginning of the second year we were able to obtain a fulltime director for our educational activities and this made all the difference in the world in the overall pattern; we now had sound planning, continuity, interest, and the participation of a great many people in the education of the staff. There was reevaluation of staff needs.

The highlights of this year's program were:

1. Attendance at classes in psychiatry at Buffalo State Hospital for the nurses who had not had recent experience in the care of the mentally ill or had not received this preparation in their basic training.

2. Six lessons in nursing care of the handicapped for all new staff nurses.

3. Classes in budgeting for the low-income family, given by the nutritionist from the

Erie County Department of Social Welfare.

4. Series of lectures in obstetrics arranged particularly for our staff.

5. Attendance of one staff nurse at a two-week institute on nursing care of the cancer patient at Roswell Park Memorial Hospital.

6. Demonstration of Massachusetts vision test to all school nurses by the director of the School Health Services.

7. Institute on eyes for everyday living for all staff, given by a worker from the Bureau of Services for the Blind, New York State Department of Social Welfare.

8. Institute on the activities of the Erie County Department of Social Welfare, presented under the guidance of the commissioner of welfare.

During this time our library was set up with about five hundred textbooks in public health and public health nursing. A parttime librarian was engaged to catalog the books and prepare them for circulation. Each district office also has a small library to which a few new reference books are added each year.

The professional magazines, including PUBLIC HEALTH NURSING, the *American Journal of Nursing*, and the *American Journal of Public Health*, were secured for each district office. Forty-three professional journals are available in the central library of the department.

Each year we select a theme for staff in-service education which we can develop throughout the year. The supervisory staff carries the major responsibility for interpretation of this new information to the staff nurses. Each year we try to have a nationally known speaker address the staff to interpret new trends in nursing and to restimulate their interest. All the time and effort we spent in inservice education pays dividends in better understanding of the job and, ultimately, in better service to the community.

Brucellosis — Another Battle to Win

ANDREW C. OFFUTT, M.D.

DURING the early years of the fourteenth century the Scottish hero Robert Bruce lay on a bed of straw, heartsick with discouragement because of the many reversals Scotland had suffered in its fight for independence from England. Bruce idly watched a spider hanging from its web and trying to swing itself from one beam to another of the cottage roof. He observed the spider make six attempts, and six times he saw it fall. "If it tries again and is successful," thought the King of Scotland, "I, too, will make another attempt to free my country." According to the story the seventh attempt of the spider was successful.

Poetically, one might conclude—either because the disease brucellosis is as complex as the spider web or the pursuit of the causative germ of the disease required the same tenacity as that of the spider—that is why Sir Robert Bruce was credited in a 1949 publication of the United States Livestock Sanitary Association with the discovery of the disease rather than the true discoverer, Sir David Bruce. A more likely explanation, however, is that this is an understandable typographical error.

Brucellosis has existed in both man and animal for several centuries and it is prevalent throughout the United States. In fact, since 1905, when for the first time a reasonably authentic case of human brucellosis originating in the United States was reported, the number of reported cases has increased to approxi-

mately seven thousand annually. This does not necessarily mean that the incidence of undulant fever (human brucellosis) is on the increase, nor does it mean that the cases reported represent accurately the prevalence of the disease. However, it does mean that as more is learned about the disease more cases are being diagnosed, and, by the same token, more complete diagnoses will occur in the future.

It is not my purpose to present a learned scientific discussion of brucellosis, but I hope that by relating some of the known and accepted facts about the disease, and by relating these facts to nursing the nurse will be in a better position to become an effective member of a team waging a successful war against brucellosis. This disease has widespread social and economic as well as public health implications. Suffice it to say that brucellosis is difficult to diagnose, because in both the acute and chronic forms it may resemble any one of several other diseases. This is such a pronounced characteristic that one of the more informative publications on brucellosis is entitled Crippler in Disguise. The prognosis is also complex and the treatment may be long, tedious, and perhaps unrewarding.

The nature of undulant fever and the associated problems lend themselves to the multidisciplined approach which has characterized the attack of health departments on other communicable diseases. This is particularly true in epidemiology where efforts should be directed toward early casefinding in those specific localities where the disease is known to exist. Unfortunately, a deterrent to the establishment of brucellosis control measures by the health departments has been the wave of new programs which have captivated the interest of public health workers. Traditional programs and methods do not stir their imaginations. The new must be pursued, but continued vigilance concerning the old must be maintained if successful achievement is to be assured.

Casefinding and control include measures to investigate and attack the reservoir of the disease. Such a program involves the close cooperation of the veterinarian and the physician. In veterinary practice animal brucellosis has long been a problem. The veterinarian is aware of the tremendous economic loss attributed to this disease. He has accepted the fact that undulant fever is more common in members of his profession than in the population at large. His knowledge and acceptance of these facts tend to spur him to increased effort for the control of this disease in animals, thus leading to a reduction in the frequency of the disease in humans.

In order to make a contribution in the control of brucellosis in man and animal the public health worker should have a background of certain basic facts. Some of the known peculiarities of the disease follow.

1. Rarely, if ever, does one human contract the disease from another human. The organism has been found in human dejecta, but in no case has it been traced to human carriers.

2. Experimental work and epidemiological studies indicate that human brucellosis may be acquired through the skin, especially when abraded, through the conjunctiva of the eye, and by ingesting infected raw dairy products.

3. Cases in children under fourteen years of age are extremely rare.

4. The incidence of the disease is highest among young adult males. Females are just as susceptible, but the opportunity for exposure is less.

5. Veterinarians and packing house workers are the occupational groups with the highest rate of occurrence of the disease. Many farmers and laboratory workers are also affected.

6. The disease in humans may be mistaken for tuberculosis, arthritis, rheumatic fever, and Hodgkin's disease before a final diagnosis is made.

7. In light of present knowledge the eradication of the disease in domestic animals is the best method of prevention and control in man.

8. Laboratory tests are essential for accurate diagnosis. Agglutination tests and/or blood cultures are acceptable procedures.

9. The principal types of the disease are:

a. Intermittent. The fever is down in the morning and up in the evening.

b. Ambulatory. The illness is mild and shortlived. The individual is able to be out of bed most of the time.

c. Undulant. Periods of fever alternate with periods in which fever is absent. This type is subject to relapses. The temperature increases by step-like gradations to the maximum in many cases.

d. Malignant. The fever remains high and death usually occurs. Fortunately, this type is rare. The onset of this type is sudden and its progression is acute.

e. Chronic. This is characterized by little or no fever and is of long duration, with protean manifestations.

There are other facts that could be added to this list, but these seem to be most significant for the nurse.

THE INTEREST and vigilance of health officers, sanitarians, nurses, and health educators in cultivating a high level of suspicion of the disease are needed to reduce its occurrence. The reporting of one case to the official health agency provides a clue which through careful investigation and follow-up may lead to the discovery of other unknown or undiagnosed cases.

Nursing has a unique contribution to make to a control program, particularly in instances where the disease appears in chronic form. The patient who with the help of the nurse develops an understanding of his disease should be able to adjust to the exigencies and complicated factors of the disease. Frequently the nurse and the physician will have to secure assistance in the care of brucellosis patients from other specialists such as the nutritionist, the social worker, and the expert in rehabilitation. A review of a number of reports of nurses who have had the opportunity to give guidance and care to patients suffering from brucellosis indicates that the greatest help they have been able to render has been with "diet, personal hygiene, emphasis on regular medical supervision, and personal adjustment."

Elaborate nursing procedures usually are not needed. The nurse working closely with the physician can do much to dispel the patient's apprehensions. Reassurance that he can recover from the disease is of prime importance to prevent the easy movement into a state of ill health, in which morass the patient may struggle for years. A positive psychotherapeutic program to accompany the drug therapy is valuable.

It is quite obvious that the problems involved in the control of brucellosis are as complex as the disease itself. Fortunately, there are sources other than the professional health worker that can be depended upon to help in the fight against disease. Community groups—citizen committees, health councils, councils of social agencies, or whatever name is used to describe the efforts of people working together to solve common problems—can get behind an organized campaign to fight brucellosis.

The public health worker will find the farmer, the farmer's wife, and his family interested in an expanded disease prevention program when they see the relationship between health programs and the economic problems associated with dairying and farming. Conservative estimates place the loss traceable from brucellosis in farm animals at approximately one hundred million dollars annually. Public health workers know that good health cannot be forced upon people, but once they have learned what good health can mean to them they work to secure these benefits for themselves, their families, and their communities.

Schools, especially the secondary schools, offer an opportunity for future homemakers and wageearners to develop an understanding of the relationship of health to total wellbeing. Brucellosis as a subject for discussion is very adaptable to the curriculum. It could be included in home economics, science, and hygiene classes, as well as in health courses.

The fight against brucellosis in man and in animals cannot be won through the efforts of any single profession or agency. It requires the coordinated efforts of many professions as well as those of all citizens.

Dr. Offutt is director, Division of Communicable Disease Control, Indiana State Board of Health.

The 1952 Census of Nurses in Public Health Work

MARGARET McLAUGHLIN, R.N.

THE ANNUAL census of nurses engaged in public health work for 1952 has been prepared in fourteen tables showing the numbers of nurses in staff and supervisory positions, their educational qualifications, and their distribution by employing agency. This is the fifteenth report made by the Division of Public Health Nursing, United States Public Health Service, in cooperation with state health departments.*

Table 1 shows that there has been a gain during each five-year period from 1937 to 1952 in the total number of nurses employed for public health work. Boards of education show the most significant gain during each five-year period since 1937. Local nonofficial agencies continue to show a loss in the number of nurses employed. Although there is a gain in the number of nurses employed by local official agencies over the fifteen-year period shown in this table, there was a slight loss in the years 1951 and 1952 from the peak number attained in 1950, when 12,726 nurses were employed by local official agencies for public health work.

The loss in the number of nurses employed by local health departments and by local voluntary agencies, though small, is significant because of the constantly expanding health programs which require nursing service and the nationwide desire to extend local health services to many areas currently without any type of public health service.

The large increase in the five-year period 1947-1952 in the number of nurses employed by national agencies and universities is due to the inclusion in the 1952 report of 166 nurses employed by the Veterans Administration, and of 60 nurses in the Army Nurse Corps employed for preventive health work. For the first time the published tables show the breakdown according to national agency. As in previous years nurses employed by industry are not included in this census.

The number of counties which have some type of fulltime public health nursing service has increased even though the total number of nurses employed for local service has decreased. Thus it appears that the population served by each generalized staff nurse is increasing each year. Is there a danger of diluting her services to the point that the desired results are not obtained? Or are we supplementing her services with other types of workers and perhaps making better use of her knowledge and skills?

Data pertaining to the number of public health nurses employed by basic schools of nursing as instructors in the preventive aspects of nursing were obtained first in 1946, when the states reported a total of 84 nurses in such positions. The 1952 data show that 201 public health nurses are now employed as instructors or coordinators in basic schools of nursing.

Ratio of Supervisors to Staff Nurses

Of the 24,919 nurses employed by state and local agencies, 2,730 were designated as supervisors and 22,189 as staff nurses, thus giving a ratio for the country as a whole of 1 supervisor (including nursing administrators and consultants) to 8.1 staff nurses. The ratio of supervisors to staff nurses in the various states ranges from 1 to 4.6 in Oregon to 1 to 17 in Wyoming. The ratio of supervisors to staff

* Complete set of fourteen tables may be secured upon request from Public Health Service, Federal Security Agency, Washington 25, D. C.

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nurses by employing agency for the country as a whole in 1952 was 1 to 9.2 in local official agencies, 1 to 42.9 in boards of education, and 1 to 5.6 in nonofficial agencies. It must be remembered, however, that in this report "supervisor" includes all nursing administrative personnel and special consultants as well as those giving direct supervision.

No special tabulation was made of the consultant nurses because a more detailed study of nurses engaged in consultation work is being made this year. The study will include information on the professional experience, postgraduate education, clinical preparation, and present functions of all consultants.

Educational Qualifications

As in preceding years, information was obtained about the general education and public health nursing preparation of nurses employed by state and local agencies for public health work.

Twenty-one states and territories had a lower percentage of nurses in 1952 than they had in 1942 who had completed one or more years of preparation in an educational program in nursing approved for public health nursing by the National Nursing Accrediting Service.* However, 30 states reported an increase in the percentage of qualified workers and 11 states made a gain of more than 10 percent during this period. The District of Columbia, New York, and South Dakota all made more than a 20 percent gain during the past ten years. As in previous years, if geographic regions are considered the western region, with 54.4 percent of all nurses qualified, ranks first. The gain for the country as a whole during this ten-year period was 8 percent (27.6 in 1942 and 35.5 in 1952).

From Table 2, which presents an analysis of the educational qualifications of staff nurses, it will be seen that 30.1 percent of all staff nurses had completed an educational program in nursing approved for public health nursing. In 1951 the percentage was 29.3. All of the agencies listed showed a slight improvement except the nonofficial agencies, which had a

* Approved for public health nursing by the National Nursing Accrediting Service after 1949, or prior to that date by the National Organization for Public Health Nursing, at the time the nurse completed her education.

TABLE 1. Total Number of Nurses Employed for Public Health Work in the United States, in the Territories of Alaska and Hawaii, and in Puerto Rico and the Virgin Islands, on January First of the Years 1937, 1942, 1947, 1952

Type of agency	1937	1942	1947	1952
Grand Total[1]	17,736	21,123	21,499	25,788
State agencies	791	864	993	1,362
Local official agencies	7,572	10,611	10,518	12,433
Local boards of education	3,477	3,913	4,637	6,456
Local nonofficial agencies	5,791	5,590	5,023	4,668
Schools of nursing	—	—	102	201
Colleges and universities (nonnursing)	—	—	—	97
National agencies[2] and universities[3]	105	145	226	571
Number of counties having no nurses engaged in fulltime public health work in rural areas	—	782	1,087	668
Number of incorporated cities and towns (population 10,000 or more) having no nurses engaged in fulltime public health work	—	32	18	13

[1] Exclusive of nurses employed by industry for this and all following tables.

[2] Veterans Administration and the Army, included o nly in the year 1952 in this table, employed 226 nurses for public health nursing work.

[3] Universities offering programs of study in public health nursing approved by the National Nursing Accrediting Service.

TABLE 2. Public Health Nursing and Academic Preparation of Staff Nurses Employed by State and Local Agencies, January 1, 1952

Type of agency	Total number*	Approved public health nursing program		One or more academic degrees	
		Number	Percent	Number	Percent
Totals	21,861	6,570	30.1	3,818	17.5
State agencies	706	341	48.3	169	23.9
Local official agencies	11,183	3,537	31.6	1,779	15.9
Local boards of education	6,068	1,802	29.7	1,212	20.0
Local nonofficial agencies	3,904	890	22.8	658	16.9

* 328 additional nurses, for whom no data on qualifications were received, were employed by these agencies.

TABLE 3. Public Health Nursing and Academic Preparation of Supervising Nurses Employed by State and Local Agencies, January 1, 1952

Type of agency	Total number*	Approved public health nursing program		One or more academic degrees	
		Number	Percent	Number	Percent
Totals	2,729	2,171	79.6	1,660	60.8
State agencies	656	568	86.6	460	70.1
Local official agencies	1,219	1,005	82.4	716	58.7
Local boards of education	147	71	48.3	71	48.3
Local nonofficial agencies	707	527	74.5	413	58.4

* One additional nurse, for whom no report of qualifications was received, was employed by these agencies.

very slight decrease in the percent of staff with academic preparation in public health nursing.

Forty-eight percent of the staff nurses in state health departments had completed an educational program in nursing approved for public health nursing. Nurses employed by local official agencies ranked next with 31.6 percent. Approximately 30 percent of the school nurses and 23 percent of the nurses in nonofficial agencies had completed their academic public health nursing preparation.

Approximately 18 percent of all staff nurses had one or more academic degrees. This is slightly better than last year. Although the staff nurses employed by state agencies again rank first there is very little difference by type of agency and very little change from the percentages reported in 1951.

From Table 3 it will be seen that approximately 80 percent of the supervisors had completed an educational program in nursing approved for public health nursing, and 61 percent had one or more academic degrees. These percentages changed only slightly since 1951 but, if they are compared with the data for 1947, the improvement is quite marked. In 1947, 73 percent of the supervisors had completed the approved public health nursing study and approximately 50 percent had one or more college degrees.

Apparent Trends

This analysis appears to indicate:

1. The number of nurses employed by local public health agencies has decreased slightly during the past two years.

2. The number of supervisors has increased steadily over the fifteen-year period, and the preparation of supervisors has improved significantly.

3. The number of nurses employed by boards of education increased consistently during each five-year period.

4. The number of public health nurses who are participating in basic nursing education programs has increased significantly.

Disinfection of Oral Thermometers

LUCILLE SOMMERMEYER, R.N., and L. DOROTHY CARROLL, R.N.

Application of laboratory research to public health nursing practice

THE RESULTS of more than two years of intensive laboratory research on methods for the disinfection of oral thermometers are being published this month in *Nursing Research* and a summary of the report is being carried in the *American Journal of Nursing*. This paper discusses several points of special application of the findings to public health nursing practice.

The final recommendations for the disinfection of oral thermometers made as a result of the laboratory investigations are:

1. Wipe the contaminated oral thermometer with a cotton ball moistened with a solution of equal parts of 95 percent ethyl alcohol and tincture of green soap.
2. Rinse the soap off the thermometer with cold running water.
3. Place the thermometer in a solution of 0.5 percent to 1.0 percent iodine in either 70 percent ethyl alcohol or 70 percent isopropyl alcohol for ten minutes.

This recommended procedure can easily be carried out in the usual public health clinic situation. However if the public health nurse is to apply these recommendations to the disinfection of oral thermometers in the home, certain adaptations must be considered. Although there is some variation in the equipment now used by public health nurses, in many instances the present equipment can probably be used.

As there was little difference in the efficacy of the various soaps tested, any solution of liquid soap probably could be used safely in the procedure recommended. Because the liquid soaps that were tested contain some alcohol they may be better cleansing agents than ordinary cake or paste soaps or soap leaves.

To allow for complete immersion of the thermometer in the disinfectant for the recommended ten minutes, the thermometer may be carried in a screw-capped test tube or a test tube with a corked stopper containing the disinfectant. However, when thermometers are carried in a disinfectant solution the colored markings are eventually removed by the solution, and because of this many agencies have discarded this method. If a small enamel instrument pan is part of the bag equipment this can be used for the disinfection procedure. A bottle of the disinfectant (0.5 percent to 1.0 percent iodine in either 70 percent ethyl alcohol or 70 percent isopropyl rubbing alcohol) must be carried also. The solution can be poured over the thermometer in the instrument pan. After the thermometer has been submerged for ten minutes the solution may be poured back into the bottle. Although tests about the number of times that the solution may be reused safely were not made it seems reasonable to assume that a daily change

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of the disinfectant solution should be sufficient.

Large cotton balls, approximately two inches in diameter, were used in the laboratory study because they seemed to clean the thermometer adequately and to offer reasonable protection to the workers' fingers during the cleansing process. Only one cotton ball was used in the cleansing procedure in the study. Although cotton was the only substance used cellulose substances which do not disintegrate easily might be substituted.

Because it is sometimes necessary to take more than one temperature in the same home two or three extra thermometers may save considerable time.

This laboratory study on methods of disinfecting mouth thermometers actually points out few major changes which should be made in the thermometer technic now practiced in many public health nursing organizations. However, laboratory data are now available which emphasize the importance of a good cleansing procedure prior to disinfection. They indicate that soap and water alone are not adequate for destroying the bacterial pathogens of the respiratory tract which may be present on the thermometer. The disinfectant solution recommended appears to be superior to either the alcohol solutions or to other disinfectants now being used.

Because the bacterial flora commonly encountered in the rectum is different from that of the respiratory tract, and because lubricants are frequently used when rectal temperatures are taken, a study of the disinfection of rectal thermometers is now in process.

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United Nations Day—October 24, 1952

MAKE THESE GOALS YOUR TOWN'S GOALS

1. In every family an observance, the sending of a UN day gift or greeting, a UN prayer, a UN meal
2. In every block or neighborhood a UN birthday party, the sending of a UN day gift or greeting
3. In every club a UN luncheon, dinner, or open house, the sending of a UN day gift or greeting
4. In every school a UN program, the sending of a UN day gift or greeting
5. In every church and synagogue a UN service, the sending of a UN day gift or greeting
6. In every camp and Uso a special UN birthday party, the sending of a UN day gift or greeting
7. In every restaurant or institution a UN menu, the sending of a UN day gift or greeting
8. In every commercial store, public building, library, a UN display or exhibit of imports, the sending of a UN day gift or greeting
9. Through every newspaper, radio, and television, a UN feature on UN birthday parties, gifts and greetings

School Nursing in the United States in 1952

WHOEVER FIRST thought of the phrase, an embarrassment of riches, must have had a sneak preview of the meeting of the NOPHN School Nursing Section at the Biennial Convention in Atlantic City in June 1952. The members of the section's planning committee knew they had done well, but even they must have been surprised to find out how well! The keynote paper, Trends in School Health Services, given by Dr. S. M. Wishik, was published in the September issue of this magazine. Five speakers then discussed trends in school nursing services as they saw them. The speakers included a parent and school personnel as well as a nurse. (We plan to bring you their papers in whole or part later.) This ended the first part of the program.

In the second half of the program fourteen nurses presented three-minute capsule answers to the question: What is happening to school nursing in your section of the country? About five hundred people in the audience hung on to every word said and many stayed to continue the discussion after eleven o'clock at night.

Following are some highlights, some summaries, some abstracts, and, in one or two instances, the entire papers of the speakers, who among them presented a picture of school nursing in the United States in 1952.

What school nurses do—Massachusetts

Today's teacher has learned much about how to stimulate and guide the individual child in his growth and development. In order to explore and develop the special interests and abilities of pupils each teacher must know something about sports, games, music, art, drama, psychology, et cetera, but no single teacher can be an expert in each of these. It is for this reason that a good school system employs and uses special services. Each of these vitalized services creates a new area of service for the school nurse.

There is the expansion and, in most communities, the introduction of formal guidance programs, augmented by psychological and psychiatric counseling. Programs in mental health have greatly increased. More classes for mentally retarded children are being established daily and thousands of these children are thus staying in school until a much more mature age than in the past.

The attendance officer in the schools today concerns himself with the cause of truancy rather than with mere numbers. In the past he often resorted to fear and punishment in handling these pupils. Today he seeks to understand why a boy or girl is a truant. He goes to the nurse for help.

With the decline of the childhood diseases, the decrease in infant mortality, and the advances in medical science, more physically handicapped children are living to school age and attending school more regularly. The diabetic, the epileptic, the rheumatic, the cerebral palsied, the deaf, the partially blind, and even the blind are now attending regular classes. The school of today is reluctant not to find a place in school for the handicapped child. The school nurse should intelligently interpret the limitations and the abilities of these children in terms of each physical handicap to the teacher. For instance, in a situation unthought of just a few years ago, legally blind children are getting their education right in the classroom, supplemented by braille instruction and braille textbooks. According to Mr. Philip G. Cashman, supervisor of special schools and classes in Massachusetts, "The direct responsibility for such a program will fall largely upon the teacher and the school nurse." Much more careful supervision and guidance for all handicapped children are to be expected from the school nurse. Referral systems in hospitals and clinics must be studied and evaluated so that the nurse will not suddenly come upon a handicapped child who has a long clinical history.

Administrators of such special programs as

speech correction, auditory training, speech reading, are vitally dependent upon the school nurse's discovery and screening of such defects for the efficiency of their programs.

There is a tremendous increase in vocational and technical schools with their attendant accidents and first aid requirements.

Of all special services personnel, the school nurse must be the most flexible.

The following illustration is familiar to all school nurses. The nurse has her schedule of work carefully planned for the day. She is going to retest eyes in the first four grades. A first grade teacher calls her and requests that she make a home visit in the early morning. She has been disturbed that Bobbie has been coming to school without his breakfast, carries an inadequate lunch, and spends his afternoons in the local movies. Bobbie's mother works every day, but today she doesn't have to be at work until twelve noon. It would be a great help if the school nurse could find out what the home conditions are. What should the teacher expect from the school nurse and what should the attitude of the school nurse be? If the nurse is rendering good service to the child and teacher she will make the home visit and do the retesting later. The nurse by giving such a service has built up an understanding and rapport with that teacher that she would otherwise never have acquired.

—Grace L. Crowe, R.N., Director of School Nurses, Public Schools, Malden, Massachusetts

What school nurses do—District of Columbia

School nursing in the public and parochial schools in the District of Columbia is carried out by the generalized public health nurse on the Health Department staff. In preparation for this panel discussion a committee of one consultant, one supervisor, and two staff nurses prepared a detailed questionnaire of 113 items, to be answered by every nurse with a school assignment. The compilation of answers presents a wealth of information. Only a few questions and summaries of the answers to the questions are discussed here.

"Which methods have you found useful in your school in securing corrections of remedial defects?" The six methods most frequently indicated were: (1) interviews with parents at the time of the medical inspection of their children (2) telephone conversations with the parents at home (3) notes sent to parents with the list of defects found by the physician (4) conferences with the pupils (5) home visits with parents (6) interviews with parents at school by appointment.

"Do you confer with individual teachers regarding the health of their pupils?" The answers revealed that this was done routinely or frequently by every nurse.

"Do you know what is being taught concerning health in the regular classroom?" Nurses in 101 schools indicated they did know what was being taught in the health field in their schools but nurses in 72 other schools seemed unaware of the health teaching in the classrooms.

"Do you instruct individual teachers concerning signs of visual disturbance, communicable diseases, hearing defects, adaptation of light to tasks, correct posture for job to be done?" Nearly 80 percent of the answers were in the affirmative. However, another question about the instruction of teachers in groups was answered largely in the negative.

—Josephine Pitman Prescott, R.N., Director, Bureau of Public Health Nursing, District of Columbia Health Department

Nurse's part in health education in elementary schools—California

From reports from the State Department of Education, the State Department of Public Health, coordinators and supervisors of school health education programs in large as well as in small school districts throughout California, it is evident that the school nursing service is well established and accepted and follows a somewhat uniform pattern, with emphasis upon health education. The service of the nurse as a health educator has not been utilized so extensively as it might be. Perhaps this is because her potentialities as an educator are not yet fully realized. The school nurse no longer can confine her activities to health

services alone but must assume more health leadership in the total educational program.

Nurses participate in the development of common understanding between administrators, teachers, and the home by serving as consultants on the adaptation of scientific health knowledge and resource material. This mutual exchange of information usually takes place at individual teacher nurse conferences, at faculty and PTA meetings, during inservice education, and in health councils. The teacher nurse conference is one of the most effective methods of exchanging health information, especially when the administrator is aware of the value received and makes plans for the conferences.

The nurse is increasingly becoming an integral part of the guidance program because of her contribution in counseling students, and in conferences with coworkers. She helps to bridge the gap between classroom guidance, home guidance, and the interview in the guidance office. This necessitates not only an intimate knowledge of the child and his home environment, but also includes observations of the child in his classroom. She must be aware of emotional health as well as physical health, and must be able to recognize when a child has a feeling of insecurity or frustration or a lack of ability or opportunity to achieve. The school nurse shares in the curriculum planning program. This phase of her responsibility is not difficult, for both the general education and the health education programs have the same basic principles and philosophy.

Health instruction receives the same academic status as other major subjects. The nurse works with the administrator, the curriculum supervisor, and the teacher in curriculum planning so that the child's needs and interests may be met at each developmental level. Working together at these different grade levels, they are able to observe the child's health interests and needs and help him to develop proper attitudes toward basic health habits for wholesome living. The nurse as a resource person supplies information on health and growth and the teacher evaluates the educational requirements.

The nurse helps to stimulate the teacher to integrate and correlate health teaching during the school day through incidental, indirect, and direct methods. She is also prepared to give specific health instruction and demonstrations in the classroom.

Frequently the nurse has been requested to participate in the family life educational program. By serving in this capacity she becomes identified as a health educator and an integral part of the instructional program in presenting basic knowledge in human growth and development. In many districts this phase of health education has been the first opportunity for her to participate in the educational program.

The school nurse shares with the teacher the supervision of the physical environment of the classroom, such as proper seating, lighting, heating, ventilation, and sanitation, all of which provide good teaching atmosphere.

There was a time when the health program consisted mainly of giving first aid, weighing and measuring the children, control of communicable diseases, and home investigations. These were considered the responsibilities of the nurse. In current years first aid technics are used to impart knowledge concerning preventive measures in safeguarding health.

The nurse is a key person in public relations. Through her home and community contacts she must accept her responsibility in helping to develop a health program in which there is close cooperation between the home and the school. There are many lines of communication between the home and the school, but the first and the obvious one is the child himself, because the health and welfare of the child are common interests of both the parent and the school.

The school nurse is one of the school team who shares in the responsibility for an effective community health education program. She must be aware of the many avenues she may use in order to strengthen her position in this phase of the school health work.

—KATHERINE EDWARDS, R.N., COORDINATOR OF HEALTH, CITY ELEMENTARY SCHOOLS, WHITTIER, CALIFORNIA

Conservation of hearing—Illinois

Three outstanding developments in this pro-

gram are: (1) a statewide Advisory Committee on Hearing Conservation and Rehabilitation (2) an institute for parents of deaf children (3) a workshop for public health nurses on the conservation of hearing.

The Advisory Committee on Hearing Conservation and Rehabilitation consists of representatives of public and private agencies in the state which are concerned with problems in the hearing field. The aims are:

(A) To promote the development of an adequate hearing conservation and rehabilitation program for the children of Illinois.

(B) To stimulate the development and coordination of services for deaf and hard of hearing children.

In the beginning consideration was given by the committee to ways in which a hearing conservation program could best be promoted. It was decided to develop a project in a local area in order to evolve a possible pattern. A county near Chicago was chosen and a statewide survey was conducted in 1948 for a period of six months, resulting in 20,663 children having audiometric examination, with 1,646 referred for otological follow-up.

The project as carried out proved:

1. The importance of a hearing conservation program for children.

2. That well selected, untrained personnel can be instructed to perform testing operations adequately.

3. That pure tone audiometric group equipment can be used accurately and speedily in a casefinding program in fourth grade and above.

4. That the screening process and the otological examination can be well and rapidly integrated.

5. That a well integrated school health program can be developed through a close working relationship between the county health department and the local school systems.

6. That a common goal such as that established by a hearing conservation program results in increased public health consciousness in a community.

7. That a shortcoming of the project as viewed after six months was the failure to include the total pre-kindergarten population in the program.

The following recommendations were made:

1. The designation of one person as coordinator with overall executive authority to maintain continuous contact with agencies participating, for the purpose of integrating their work and to secure cooperation and develop resources.

2. The conservation of hearing program should become a part of the regular school health service in order to insure its continuation.

3. Otological screening clinics should be included as part of the hearing conservation program.

4. Local educators should be brought in on all planning from the beginning and a person trained in special education should be a member of the project team.

5. A local representative advisory committee should take major planning responsibility.

6. Similar projects should be extended to other counties in the state, but only in those counties having a fulltime health department with a health educator on the staff and a program of special education in the school system.

The advisory committee continues to be very active. It has stimulated interest in a program for the children in the Chicago schools. The committee is concerned with legislation, with recruitment of teachers in special education, with rehabilitation, and with ways to further the education of the public in this field.

—Maude B. Carson, R.N., Chief, Bureau of Nursing, Illinois State Department of Public Health

Administration of school nursing—Pittsburgh

The population of Pittsburgh is about 650,000, including approximately 120,000 children of school age and 106,000 past school age.

Nursing services for both public and parochial school children are provided through the generalized public health nursing program of the Department of Health. The program includes services to infants, preschool children, and school children, and for tuberculosis, venereal disease, and acute communicable disease patients.

In Pittsburgh only two agencies offer public health nursing services, the Health Depart-

ment and the vna. In one section of the city the public health nurses of the two services have been participating in a combined program since March 1952. In this combined nursing service a single nurse provides families with bedside nursing care in the home along with the so-called preventive services of the Health Department. In addition to the services rendered in the home each nurse spends about one day in schools and about half a day each week in child health conferences.

These scheduled assignments and the demands for family health services, including nursing care of the sick, do not seem to present situations which cannot be easily adjusted. For instance, recently a diabetic patient was referred for instruction in the administration of insulin. When this call was given to the nurse she recognized that the family name and address were those of a child known to her through the school and to whom she had planned to make a visit to discuss the need for an eye examination. The nurse immediately related the illness to the fact that the mother had not responded to a request to come to the school to discuss the child's health needs.

The nurse was scheduled to be in school at 9 a.m. and she made arrangements to be in the home at 8 a.m. to begin teaching the administration of insulin. (Ordinarily she would be on duty at 8:30 a.m.) While the nurse was in the home she talked about the child of elementary school age who ought to have an eye examination. The mother said the daughter in senior high school would accompany the child. Incidentally, the mother could not be taught to give insulin because of poor vision and the high school girl was taught the procedure. The nurse made arrangements with the school counselor for the high school girl to be late for the few mornings during which she learned to give her mother insulin. The nurse also met an older married daughter who was staying in the home because of the mother's illness. She was an expectant mother and was directed to medical care.

More and more the nurses in the combination area and in other areas of the city are relating their services to school-age children to other family health services. This is increasingly satisfying to the nurse and, there is reason to believe, to families.

—Alberta B. Wilson, R.N., Chief, Bureau of Public Health Nursing, Department of Public Health, Pittsburgh, Pennsylvania

Administration of school nursing—Buffalo

The administration of the school nursing program in Buffalo is under the Erie County Department of Health, but in the county it is under local boards of education. This creates a dichotomy but the situation is fairly typical throughout the state. The Health Department gives generalized and specialized services to the 100,000 children in the public and parochial schools in Buffalo. The local boards of education employ school nurse-teachers for the approximately 35,000 children in schools in rural areas of the county. When the school nurse-teachers are unable to cover the schools the generalized public health nursing service in the local area steps in and supplies school nursing as part of its family nursing program.

As a matter of fact, many more agencies are involved in providing health and welfare services to children, but we believe their goals are identical. In 1945 the departments of health, social welfare, mental hygiene, and education set up the Inter-Departmental Health Council of New York State to secure better coordination of their programs for the purpose of improving their facilities for school children.

Recently a survey of Buffalo schools was undertaken by a group of experts. Even before the survey was made we were aware of most of our shortcomings and had made plans to improve our services.

We consider the following to be the strengths of our program:

A. Qualified public health nursing personnel: New York State registration, a degree in public health nursing or one year of study in public health nursing. The New York State Department of Education has agreed to evaluate the qualifications of our public health nursing staff and to certify them as school nurse-teachers when they meet the qualifications.

B. Inservice education for public health nursing staff.

C. A fairly adequate ratio of public health nursing staff to pupils:

1948—1 public health nurse to 2,147 pupils.

1951—1 public health nurse to 1,688 pupils.

Goal—1 public health nurse to 1,500 pupils.

D. Adequate supervision of public health nursing staff; 1 supervising public health nurse to 12 public health nurses.

E. Graded priorities on home visits according to significance.

F. Program of referrals to specialized services within the department or associated facilities: (1) medical rehabilitation (2) hard of hearing (3) cardiac (4) orthodontia (5) cerebral palsy (6) exceptional children (7) dental prophylaxis and dental care (8) child psychologist.

G. Spaced physical examinations in grades 1, 4, 7, 9 and 12, with parents present at examinations in grades 1 and 4.

The needs of our program as indicated by the survey are:

A. An administrative council on school health with representation from the departments of health, social welfare, mental hygiene, and education to (1) establish policies (2) review health procedures (3) make administrative decisions in the interest of improved health.

B. Improved teacher participation and the understanding by both physicians and public health nurse of the school program.

C. Cumulative health records.

D. Teacher observation record.

E. Promotion of fluoridation of water.

F. Improvement of health suites.

G. Hearing tests to be given more frequently than in grades 2, 4, and 6.

H. Annual vision tests.

I. Provision of clerical assistance for public health nurses in school to free them for health education and also for health counseling.

J. Better coordination of school program and community agencies.

K. Introduction of posture program.

—Ruth E. Rives, R.N., Director of Nursing, Erie County Health Department, New York

School health policies—New London, Connecticut

It has always been surprising that whenever a large group of school nurses meet together many report that although they have school health policies they are not written policies. We have found that written policies are necessary if misunderstandings are to be avoided. They should be determined by the professional health and educational administrators with participation of those groups who are expected to help carry out the policies. In other words, the thinking of the staff nurses, teachers, principals, and, in some cases, special workers, should be secured if practical working policies are to be set up.

In New London school health policies have been determined in the slow democratic way; everyone concerned has been consulted and the School Health Council has been asked to approve additions, changes, or revisions before they have been officially adopted. Since 1916 the school health service has been administered by the Health Department and this has proved satisfactory under three school superintendents. In 1951 service to the high school was added to the program.

There are written school health policies to cover the following: physical examinations, health record, illness and emergencies, dental program, attendance, prevention and control of communicable diseases, exclusions and readmissions, and nurse-teacher conferences. In preparing these we have considered both the health and educational points of view and we have made changes when necessary.

Steps in formulating a policy:

1. Need for policy or change may be recognized first by nurses or administrators.

2. Supervising nurse discusses the policy with the nurses and administrators.

3. Policy is written.

4. Review with nurses who carry out policy.

5. Acquaint all personnel with the change or new policy.

6. Present to School Health Council for approval.

—Alice C. Greene, R.N., Supervisor of School Health Service, New London Department of Health

State Interdepartmental committee—Arkansas

Arkansas is a rural state with many children, not many workers, and not much money. Two of the state agencies most directly concerned with the health of the school children, namely, the state departments of health and education, have developed a cooperative working relationship directed toward providing the very best health status for all the school children that is possible with the resources available.

For several years "pilot school health programs" were carried on in a number of Arkansas schools through the joint sponsorship of the state departments of health and education. The purpose of these projects has been to demonstrate the kind of school health program that can be developed with the facilities and personnel available in varying types of situations. Summer work conferences in 1948 and 1949 were directed toward evaluating experiences at these schools and setting forth promising practices which might be used as a guide for further progress.

At the 1949 work conferences a committee was assigned the job of "formulating a plan by which health education can be extended into all schools and communities in Arkansas." Health education was interpreted broadly to include healthful environment, health teaching, and services for healthful living. The committee comprised representatives of the health and education departments at the state and local levels. The recommendations of this committee included one for the formation of a permanent joint school health committee and another for the publication of a simple guide for the improvement of school health services.

The joint committee was formed soon thereafter and has held regular meetings, usually at monthly intervals. The director of public health nursing and the public health nursing consultant in maternal and child health of the State Health Department are permanent members of the committee.

The joint planning directed toward improving the health of the school children of the state is bringing desired results. Among these are the warm solidarity between the state health and education departments; the coordination of activities and the prevention of overlapping and duplication. The nurses report a much better understanding by school administrators of the function of a public health nurse; she is now used more for consultation and follow-up and less for exclusions for nuisance infestations.

—Mary Emma Smith, R.N., Public Health Nursing Consultant, Arkansas State Board of Health

School nurse supervisors—New Jersey

Under the leadership of the nurse consultant of the State Department of Education the school nurse supervisors of New Jersey organized two years ago to form the Association of School Nurse Supervisors. It is believed to be the only one in the United States.

Two one-day meetings are held each year, one in the fall and one in the spring. Each supervisor extends through her superintendent of schools an invitation to hold the meeting in his district. This gives the membership an opportunity to observe the health programs of other systems, to tour the many new school buildings, and to lunch in the school cafeterias. It gives the superintendent an opportunity to become acquainted with the aims and objectives of the supervisors' association and to observe that it is a professionally-minded group.

New Jersey has a number of school districts with a one-school nurse service but in the overall program the ratio is one supervisor to six nurses. In one large system the supervisor with a staff of forty-four nurses also supervises four teacher nurses who are certificated high school teachers. In another system the supervisor with a staff of fifty-one nurses also supervises eight teacher nurses who are certificated high school teachers. No district has more than one fulltime supervisor.

The association meetings have been devoted to such discussions as The Construction and

Effective Use of a School Nursing Manual, Evaluating the Work and Contribution of the School Nurse to Child Health, and The Supervisor Conducts the Nursing Conference in a Professional Manner.

At present all nurses whether serving on the staff or in a supervisory capacity are certificated by the State Department of Education as school nurses. The association has appointed a committee to set up suggested supervisor qualification requirements to be submitted to the state department for consideration.

We trust that in the near future certification for school nurse supervisors will be made available.

—Florence L. Savage, R.N., Supervising Nurse, Morristown Public Schools

School nurse-teacher—New York

On May 1, 1952, 1,084 school nurse-teachers were employed by boards of education in New York State. These nurse-teachers are supervised by the members of the Bureau of Health Service, Division of Pupil Personnel Services, State Education Department. There is an increasing tendency toward employment of school nurse-teacher supervisors at the local level.

In New York State school nurse-teachers are certificated by the Office of Teacher Certification, State Education Department. A ten-year provisional certificate is issued upon completion of thirty prescribed college credits. Upon completion of thirty additional credits a permanent ten-year certificate is granted with six inservice credits required each ten years thereafter to validate the permanent certificate. Every year more school systems raise their local standards and employ only school nurse-teachers who have bachelor's degrees.

School nurse-teachers are employed in 59 cities, 100 villages, and 154 school districts in New York State. They are on teacher salary schedule, have tenure, and are members of the New York State Retirement System.

Recommended standard for the employment of school nurse-teachers:

In rural areas 1 school nurse-teacher to 500 pupils.

In urban areas 1 school nurse-teacher to 1,000 pupils.

Actual school nurse-teacher-pupil ratios:

In rural areas 1 school nurse-teacher to 914 pupils.

In urban areas 1 school nurse-teacher to 1,360 pupils.

Forty-nine percent of all school nurse-teachers do all or much of the attendance supervision. The recommended standard for the reduction of pupil load with this added duty is 1½ hours per week per 100 pupils.

Twenty-two percent of all school nurse-teachers take the school census in August.

The New York State School Nurse-Teacher Association has a membership of 745 school nurses. There are fifty-five organized county school nurse-teacher groups. These county groups plan two to ten meetings yearly.

Current trends recently noted:

1. Increasing number of school health councils to improve and extend communications and provide a cooperative means of solving school health problems.

2. For the past four years approximately 100 school nurse-teachers per year have been employed in new positions or have been added to established programs.

3. Reduction in assignment of school nurse-teachers as attendance supervisors.

4. An increasing number of schools each year exceed the minimum legal requirements of the New York State Education Law and the commissioner's regulations in their health service programs.

5. An ever increasing number of schools and school districts choose to own their group and pure tone audiometer equipment.

6. The trend toward better health suites is concomitant with the extensive school building program in the state.

7. Interagency and community cooperation has been stimulated by the work of the New York State Inter-Departmental Health Council appointed in October 1946.

—Josephine McFarland, R.N., Associate in School Nursing, Bureau of Health Service, Division of Pupil Personnel Services, State Education Department, New York

Certification—New Hampshire

In New Hampshire there are no colleges or universities which offer courses in public health nursing. When new certification requirements were set up for school nurse-teachers it was necessary to make plans to help the nurses to meet the requirements. A committee appointed by the School Nurse-Teacher Association found that the nurses could meet some of the requirements through two-week summer workshops. In 1951 20 percent of the school nurse-teachers in the state took advantage of a workshop on recent trends in the school health program, given at one of the teachers colleges. In 1952 a second course was added and about 35 percent of the nurses attended the two workshops. Attendance at each workshop carries two semester hours of credit toward certification.

With the increase in demands by the nurse-teachers we hope that eventually the colleges in the state will offer a number of professional programs.

—Annette L. Eveleth, R.N., Director of School Health Services, New Hampshire State Department of Education

Certification—Pennsylvania

The nurse in school plays an essential part in the education program and is bound to play a still more important part in the schools of the future. The preparation of the nurse serving in Pennsylvania's public schools has been emphasized since 1920 when certification was first required for the position of school nurse in the commonwealth. On September 1, 1952, a new program of certification went into effect.

A state standard limited certificate is issued for three years upon satisfactory completion of twelve semester hours of professional education of collegiate grade. This certificate is renewable for three years upon a rating of satisfactory. The state standard limited certificate will be exchanged for a provisional college certificate when the candidate has earned a baccalaureate degree in nursing education.

The new program governs the issuance of new certificates only. It does not affect temporary, special, normal, or provisional college certificates now valid, as all such certificates will be renewed and made permanent in accordance with the requirements under which they were issued.

—Miriam Y. Schepler, R.N., Chairman, School Nursing Section, PSNA

Certification—Rhode Island

In January 1947, at a meeting of the School Nurses' Section of the Rhode Island State Organization for Public Health Nursing, a committee was appointed to collect data to provide a basis for requesting a salary increase. About that time a bill was to be presented by the Rhode Island Institute of Instruction to the General Assembly, requesting a $600 increase in salary for all certified teachers. Later this was given in the form of an annual state salary grant.

The committee first met with the president of the Rhode Island Institute of Instruction to discuss the problem with him and he agreed to work with the committee to have school nurses covered in the provisions of this bill.

Later the chairman of the House Finance Committee arranged a meeting between the nurses' committee and the governor. The governor stated that if the nurses obtained teacher certification he would recommend the needed money. Therefore, in April 1947 the committee met with the state director of education to discuss the possibility of nurse-teacher certification. The director agreed to work for certification of school nurses and in September 1947 a bill was passed requiring certification of school nurses employed by boards of education in Rhode Island.

After this a committee, including school administrators and public health nurses, was appointed by the state director of education to set up a program of study through which nurses might qualify. Applicants must meet the following requirements:

1. Graduation from an accredited school of nursing.
2. Registration in Rhode Island.
3. One course in the required program of study must be taken in each semester and a

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A Village in the Delhi Province

SUMATRAI DESAI, R.N.

CHAWLA is coming into the limelight. Today it has assumed a special importance among the thousands of those tiny little villages that dot the Indian landscape, for it has been blessed with the attention of national and international health teams, which are tackling its varied health problems. Chawla is indeed a fortunate village in the eyes of the newly awakened villagers and in the eyes of most Indians who have become conscious of the importance of villages in their country.

Chawla is about twenty miles away from Delhi and is just a cluster of about three hundred huts where nearly eighteen hundred people lead a more or less self-sufficient life. The bulk of the community consists of "zamindars" or peasant proprietors, each one having his own piece of land which he cultivates and irrigates with the help of wells. He enjoys the harvest of two crops during a year, wheat, barley, gram, and mustard in April, and "bajra" and "jwar" (millet) in October. The farming is mainly individualistic and whatever cooperative cultivation exists is limited to families in the joint family system. There are other workers such as shoemakers, weavers, and barbers, whose jobs are determined by family tradition. Money does not play an important role in the day-to-day life of the community. The barter system, which is an ideal practical substitute, secures all their limited needs.

IF WE WANT to picture an individual's life in a village from the health point of view we can start at the prenatal period. The mothers are well nourished in spite of the fact that they are vegetarians, for there is no lack of first-class protein in the form of milk, which is used plentifully. The poorer people who cannot afford milk have buttermilk, which is often given free to them by the zamindars who discard it after taking out "ghee" (clarified butter). The principal cereal grains consumed are wheat, barley, bajra, and jwar. As it is the custom here to grind the flour at home most of the important vitamins are preserved. Few vegetables are eaten by the villagers. Those which are available are brought from quite a distance away from the village and are expensive. However, there are certain green leafy vegetables which grow wild near the village which are eaten by the people. Onions and carrots when in season are plentiful and are eaten in large quantities, which help to meet the individual's need for iron. On the whole, we find the villagers' diet well balanced.

The out-of-door life provides plenty of sunshine and fresh air. However, cleanliness presents problems. The water supply is limited, especially in the summer months. There is a great deal of dust, also. Houses have cow dung plaster flooring, and because the villagers have a habit of sitting on the floor their clothes get dirty in a short time. Also, since manu-

This article about life in an Indian village and the practices attendant upon childbirth and the care of young children was written by a twenty-one-year-old Indian nurse. She is attached to a team working in Delhi Province in connection with an internationally-assisted training center for nurses and midwives. The Delhi project is one of several in India that are being carried on by the government with the help of the United Nations International Children's Emergency Fund and the World Health Organization. The objective is to build up a corps of trained people who in turn can train others for work in both urban and rural areas.

India today has only one nurse for every 6,300 inhabitants, only one health visitor for every 400,000 inhabitants, and only one trained midwife

factured soaps and substitutes are not easily available and soap has never been made locally it is difficult to speak convincingly about cleanliness to the village women. It is a hard task to convince people of the need for having a really clean place for delivery. The delivery room is often a dingy back room filled with primitive furniture and piles of fodder. In homes where there is just one room the delivery may be conducted in the room in which the cattle are kept. We still see cases where the delivery is conducted with the woman sitting on a pile of dried cow dung cakes. It sounds appalling to conduct a case in such surroundings but often it has to be done, and it is possible to conduct a safe delivery in these homes in spite of the unhealthy surroundings.

The importance of prenatal care is not understood and it is difficult to persuade pregnant women to come to the clinic regularly. They are afraid that these examinations will harm them.

A village mother's psychological attitude toward pregnancy presents no problem, as children are regarded as gifts from God. Very few village women show a dread of the impending delivery. They face it with a confidence rare to be seen in city mothers. We seldom hear a woman in labor, even a primipara, cry out because women in labor are not supposed to complain of having too much pain. Work is done until the last moment and all the hard work develops good muscle tone and helps to make the delivery easier. Many times the baby is born before the arrival of the midwife.

Many rituals and customs are practiced at the time of delivery, such as opening all the locks in the house, untying the hair of the woman in labor, putting hot ashes underneath the bed, keeping a sharp instrument under the pillow. All these things are believed to hasten delivery and few of them interfere with the fundamentals of conducting a delivery in the proper way. Of course, adjustments have to be made to the particular situations. Another point on which the villagers are insistent is that they do not allow the cord to be cut until the placenta has been delivered, for they believe that if the baby is separated from the mother the placenta may be retained in the uterus. Although this makes it necessary for the nurse to keep the child in somewhat dirty surroundings for a time it gives the baby a chance to receive more of the placental blood.

AFTER DELIVERY the mother is expected to rest for forty days. For the first ten days she is segregated from the rest of the family and mother and child are looked after by an elderly woman. During this period the mother has a special diet which is limited to very rich food containing plenty of ghee, practically no grains, and very little fluids. But rarely do we find the mother having gastric upsets or the baby having diarrhea or any allied troubles, and in spite of the dirty surroundings the maternal mortality rate is remarkably low in normal cases.

The older children take the birth in a matter-of-fact manner and welcome the new arrival. There is very little about a delivery which is kept hush-hush from children. As soon as the child is a year old or so he passes under the care of the older children or the grandmother, so the toddler rarely feels that he is neglected because of the new one.

During infancy the child is wholly breast fed. Mothers' milk usually is abundant and is considered to be the best food for the child. On the whole, the infants are healthy. The mothers do not see the necessity of visiting clinics when the babies are not actually ill, but some health supervision is done in home visits.

The crucial time for a baby comes with weaning. At this stage the child is passed on

for every 60,000 inhabitants. The country not only lacks people with these skills, it also lacks places where they might be trained.

As a first step the Indian government sought the help of UNICEF and WHO in establishing a training field in the Delhi area, where practice in both the urban area and in the nearby villages could be combined with formal training. To that end WHO offered its technical assistance and UNICEF provided supplies and equipment. As a further help UNICEF has also provided basic equipment and supplies for a hundred maternal and child health centers and drug and diet supplements. UNICEF and WHO have also aided the government in its development of pediatrics training centers in Madras, Bombay, and Patna.

to the grandmother or to an older child when the mother is busy with work. The child has learned to crawl about and explores the muddy surroundings. He remains dirty most of the time and gets into the habit of eating mud. When the mother's breast milk supply dries up the child is given adult food and buffalo and cow milk. There is no question of careful preparation of milk. Either it is given whole or in the dilution which the mother seems to concoct without regard to any recommended formula. Special diets for children are not known. This is why we find that preschool children are emaciated and generally suffer from diarrhea. The death rate is comparatively high at this stage of childhood. However, as soon as the children make a good adjustment to adult food they grow up without much difficulty and become sturdy adults like their fathers and mothers.

Signs of improvements in Chawla are perceptible. The two world wars have brought about certain beneficial changes. The men were drawn out of the villages, introduced to the fast moving life of the world, and then sent back to the villages. They are conscious that better ways of living are possible, and that is a beginning in the direction of progressive improvement.

There are schools for boys and girls which at least give the children an opportunity to learn the "three Rs." The facilities are mainly utilized by the two higher classes, Brahmans and Jats, but a few of the lower classes have also started coming into the schools now. These schools offer the most effective channel through which we can spread the idea that prevention is better than cure.

The villagers are trying to extend the existing primary school into a secondary school. Although the adults of the village want more education for themselves and their children it is mainly the men who are interested in it. At present Delhi State with the help of UNESCO has started an adult education plan. An education exhibition dealing with various subjects of interest to the villagers is held for a week. After this a group of teachers stay in the village for one month and teach the villagers to read and write. The students are then taken over by the village schoolmaster. Once the community is educated improvements in other directions will be easier to make, especially in the betterment of the villagers' economic status. Lectures, slides, and films are not likely to prove very effective methods of education without a background of literacy.

Individual efforts toward improvement can be seen in the houses. They are now built "pucca" (with bricks and plaster) when enough money is available. The use of windows and ventilators is coming into fashion. Also, a few private houses have soakage pits and borehole latrines, which were provided practically free of cost by the Public Health Department.

AT PRESENT the village people seem to realize the need for medical facilities, but the awakening has not been effective in inducing them to do anything on their own initiative. Preventive measures have little appeal to the villagers. Of course, when their acute need for medical help is not met in a satisfactory manner it is hard to convince them of the importance of preventive measures to promote health. It is not so much a problem of lack of money as lack of willingness and belief in the need for improved conditions and habits. Although a few village folk who have had a chance to see the conveniences of city life appreciate those facilities they don't consider introducing similar improvements in the village. The problem at present is to convince them that a modification and not a complete change is required in their ways of living. They need reassurance that their ways of living are not entirely to be condemned, that they have some good points, such as the vigorous out-of-door life and the simple but nourishing food.

A public health nurse because of her skill and knowledge of modern medical science and preventive medicine can easily gain the confidence of the villagers. Then with her understanding of their social and economic background and its effect on human psychology she can help the villager to make gradual effective changes in his ways of living. Hence, she is an indispensable member of any team doing village reconstruction.

It is true that outside help in funds and personnel is not the only thing which is required. Some encouraging and organizing force is also required. That force has to come from the villager. We who are interested in effective rural welfare work, which is aimed at helping the villager to help himself, have to work very hard and face many failures before we get any encouraging results. In order to make improvements permanent we have to work constantly and with no time limit. We must develop efficient family health services and school health programs, organize good community-wide programs to improve village houses, roads, and water supply, along with other programs for improvement in local education, agriculture, cottage industries, et cetera.

Thus, through a comprehensive and at the same time an intensive program which is guided by the expressed needs of the villager we may bring about progressive improvement in the standard of living. Then only we may hope to find Chawla in the future a neat, clean, and prosperous village with healthy inhabitants, proud of their wellbeing.

Stress in Everyday Life

LIFE'S EXPERIENCE includes a series of hurdles which each individual is required to clear in the race to fulfillment. Each hurdle represents a stress situation—entering school, adolescence, the choice of a vocation, young adulthood, the selection of a mate, and marriage, parenthood, the raising of the family, middle life, the "empty nest," retirement, the autumnal years, senescence. The progression from stage to stage is fraught with hazard, and about each of these nodal periods there cluster innumerable wrecks and failures. Why cannot we ease passage and safeguard the transient? Why can we not provide such guidance, such instruction, such assistance as will help the fledgling school child, the adolescent, the young boy in search of a vocation, the young married couple, the bewildered and bedevilled parent—to meet effectively his and her stress situation?

—IAGO GALDSTON, M.D.
FROM THE HEALTH OF EIGHT MILLION

Why People Who Are Not Nurses Are Needed in NLN

EDITH WENSLEY

MANY OF you may remember the case of the very timid man who visited a mental hospital. He was shown through the wards by a frail-looking psychiatrist. As they progressed, the patients seemed to become more burly and to have a more dangerous gleam in their eyes. At last the visitor could stand it no longer. He dragged the little physician into the hall and whispered: "Doctor, do you realize what would happen to you if these people should get together?" To which the little psychiatrist replied, "If these people could get together, they would not be where they are now."

I tell this apparently remote story because it illustrates a subject of extreme importance to all of us. This subject is cooperation. All our efforts to restructure the national nursing organizations were really efforts to achieve greater cooperation in nursing than we had had—cooperation among nurses in all kinds of positions and fields of nursing, and cooperation between nurses and those of us who are variously called laymen, general citizens, non-nurses.

Have you stopped to think how essential this cooperation between nurses and those of us who are not nurses has been in the progress of nursing—from the very beginnings up to the present moment? In fact, without this cooperation it is difficult to see how there would be any organized nursing services in communities today or any organized facilities for providing nursing education.

Mrs. Wensley is director of public relations, National League for Nursing. *This paper is based on a talk she gave at the last meeting of the* NOPHN *Board and Committee Members Section in Atlantic City in June 1952.*

To illustrate this point, we could talk about the beginnings of almost any nursing service that has been organized in a community or about almost any school of nursing or other educational unit. But let's take the founding of the first modern public health nursing association. For two reasons this is a good example to illustrate cooperation between members of the nursing profession and those who are interested in nursing from the point of view of the consumer. It's a good example, first, because most of us here are familiar with it. And, second, because it is concerned with both nursing service and education.

You will remember that around the middle of the last century William Rathbone, who was a merchant and member of Parliament in England, became convinced that the people of Liverpool needed a nursing service in their homes that would be provided by the community. Acting on the advice of Florence Nightingale, he started a visiting nurse service which employed a nurse to make parttime visits in the homes of the sick. After several months, the nurse, Mrs. Mary Robinson, became so discouraged that she was ready to give up the experiment. But Mr. Rathbone encouraged her to continue until she, too, became convinced that visiting nursing was an essential community service.

As the organization grew and more and more nurses were employed, it became evident that some arrangements needed to be made so that it would be staffed by nurses with systematic training. Again acting on Florence Nightingale's advice, Mr. Rathbone made such arrangements by building a nurses' home for the Royal Liverpool Infirmary. So, right from the start we see that the importance of *correlating nursing service and education* and

the need for close *cooperation* between nurses and the people who receive their service were recognized.

If we trace the history of nursing right down to the present moment, we see this pattern of cooperation repeated again and again. Wherever a nursing service has been organized in a community or wherever facilities for nursing education have been established, there has inevitably been such cooperation.

EVEN SO, there are some people who understand the role that nonnurses inevitably play in the founding of a community nursing service or of a school of nursing, but they do not understand so clearly why they are needed as members and participants in the brand-new National League for Nursing. In fact, a number of board members of visiting nurse associations have said to me, "This new organization, the National League for Nursing, sounds so utterly *professional* that I don't see where I fit in. What, for instance, do I have to do with setting standards, or with accrediting educational programs in nursing, or, for that matter, with *any* of the objectives as stated in the NLN bylaws? Isn't it up to *nurses* to do those things?"

Perhaps the best way to answer that question is to ask one. How could nurses all by themselves carry out the NLN objectives which are, as you know, only a means to an end? They are only a means of achieving NLN's overall goal which is to foster the development and improvement of hospital, industrial, public health, and other organized nursing services, and of nursing education, to the end that the nursing needs of the people will be met. This is certainly of vital importance to you and to me and to our families.

Let me ask some other questions. Are *only nurses* concerned with the way a service is organized in a community? Or is the community—that is, you as potential consumers of nursing service, as community representatives, as contributors—equally concerned? Are *only nurses* responsible for seeing that there are adequate and good facilities for providing nurses with the education they need to give good nursing service? Or are you who are not nurses also concerned? Are *only nurses* responsible for seeing that the people are receiving good nursing service and that nurses are receiving the kind of education they need to give good nursing service? Or is this responsibility shared with you who are members of boards and committees and with members of allied professional groups that work with nurses—that is, with physicians, hospital administrators, other administrators, and teachers in the institutions that provide nursing education? Don't those of us who are not nurses need to cooperate with nurses in seeing that standards in nursing education and nursing services are such that they provide sufficient protection to the people? Can nurses all by themselves decide what the nursing needs of the people are and whether or not they are being met? Don't the people—or at least some responsible and well informed representatives of the people—have some valuable opinions and suggestions in regard to this? Whoever we are, don't we all have an equal stake in seeing that nursing service, *good* nursing service, is available when we and our families need it?

The answers to all of these questions should make it clear why *your* participation in the NLN and participation by other persons who are not professionally engaged in nursing are so essential. But all of this could be stated another way—or, rather, summed up in two basic reasons.

The first reason is allied to the fact that the United States is a democracy and that we believe democracy should be not only a form of government but also a way of life. In a democracy the people should have a share in planning and guiding the programs that affect them. The new National League for Nursing is concerned with planning and guiding programs that affect other persons as well as nurses. It is only democratic, therefore, that those persons, as well as nurses, should have a share in the planning and guiding.

The second reason is equally important. Very simply it is this: NLN can achieve its objective *only* with the help and participation of people who are not nurses—that is, through the *coordinated action* of professional nurses, members of allied professional groups, and other citizens who are concerned with nursing

services and nursing education. We know that the effectiveness of a program that concerns the people in general is enhanced when nonprofessionals as well as professionals have a part in it. Although an organization like the NLN, or many of the well known national health organizations, needs a professional core, it is questionable whether it could begin to realize its full potentialities if only the professional people directly engaged in that line of endeavor take part in it.

PROBABLY you are familiar with this under the general title of "citizen participation," for we are all hearing a great deal about that subject these days. In a way, it is curious that we have to be reminded that general citizens need to participate in the organizations that are so important to their health and welfare. Actually, what we call "citizen participation" antedates professional participation. Because in the beginning was the layman. There is no doubt as there is with the chicken and the egg about which came first, the layman or the professional. The layman definitely came first and pointed to the need for the professional.

It would be unrealistic to ignore the fact that a few nurses are apprehensive about nonnurse members in the NLN. For instance, a few nurses must wonder, sometimes out loud, whether nonnurse members in the NLN will have some share in deciding the content of professional nursing education. I am sure that nonnurses would be the first to say that such a decision is solely within the province of professional nurses to make, although we would imagine that before making a final decision on even this subject, nurses might want suggestions from educators who are not nurses. We who are not nurses would not propose the technical content of nursing education or the methods of presentation in nursing education. But our own experience with nurses tells us what they do that proves satisfactory to patients and where a different emphasis in their training or preparation might make them more satisfying nurses. We might also point out that the position of people who are not nurses in regard to the content of nursing education would be somewhat similar to their position in regard to the content of the nursing visits.

Many of you are members of boards of directors, responsible for the overall management of visiting nurse associations. Some nurses who are not familiar with the way you work might wonder if you make any decisions with regard to the content of your staff's nursing visits in homes, but I am sure that none of you does. I am sure that you assume responsibility for all matters in your agency that are properly those of the board and leave to the nurses all those matters that are strictly professional, working together on all matters that are of joint concern.

It is the same way in the National League for Nursing.

NOW, TO GET to specific details about the new organization. I'm assuming that you are all familiar with the fact that the bylaws provide for two divisions, a Division of Nursing Services and a Division of Nursing Education. Under the Division of Nursing Services, there are two departments, the Department of Public Health Nursing and the Department of Hospital Nursing. Under the Division of Nursing Education, there are also two departments, the Department of Baccalaureate and Higher Degree Programs and the Department of Diploma and Associate Degree Programs. Those of us who are not nurses, just like the nurses, are eligible to join any one of these departments and to participate and vote in appropriate meetings of that department. We are also eligible to participate, but not to vote, in meetings of the other departments. This means that if you happen to be a member of a school of nursing committee and, at the same time a member of the board of directors of a visiting nurse association, you have to decide whether you prefer to be associated more directly, as far as the NLN is concerned, with activities connected with nursing services or with activities connected with nursing education.

As a nonnurse member, you are also eligible to serve as a member of the board of directors, as an officer (but not as president or first vice-president) as a member of the committee on nominations, and as a member of all standing and special committees. These include the

committees appointed by the board of directors, the steering committees elected by the members of each department, and the committees appointed by the divisional and departmental steering committees. You are also eligible to represent your agency, if it is an agency member, at NLN meetings—including meetings of agency representatives from organizations similar to yours. For instance, in the Council of Public Health Nursing Agencies under the Department of Public Health Nursing, you—if you are a board member of a visiting nurse association—might be appointed as one of your agency's representatives.

At the first meeting of the NLN Board of Directors an interdivisional committee on nonnurse participation was established. This was requested by the executive committee of the former NOPHN Board and Committee Members Section and, in effect, replaces the section.

When state leagues for nursing are organized, we expect that the same provisions will be followed there. In other words, we who are not nurses are not to be relegated to a little corner by ourselves. We are to have an unprecedented opportunity to cooperate with nurses throughout the new organization in helping to make sure that nurses have the kind of education *they* need to give us the services *we* need, and in helping to make sure that the people in *our* community have the kind and amount of nursing service they need to get well and to keep as well as possible. It is an organization in which the points of view of the nurse and the nonnurse will be pooled for the common good. And it is an organization in which the nonnurse members are as important in their role as the nurse members are in theirs.

As far as I know, there is no other organization quite like the NLN either here or anywhere else in the world. In fact, the more we think about this new organization, the more convinced we become that it could not happen in many places in the world—so thoroughly American is it in ideals and methods of working. Think of it, a completely unique organization—an *American* organization—of which you have the honor to be a member! I hope you'll be not only a life-long member but a life-long *active* member.

School Nursing—1952

(Continued from page 571)

total of four credits acquired in a school year.

4. Completion of the thirty semester hours in an eight-year period.

Nurses who had fifteen years experience in the field of school nursing as of July 1, 1949, were allowed eight credits toward certification. A provisional certificate is granted yearly until the nurse has completed thirty semester hours of required study, at which time a five-year professional certificate is issued.

At present there are forty-eight nurse-teachers in Rhode Island under boards of education. Of these, twenty have completed the thirty semester hours of study and have qualified for the five-year professional certificate.

—HELEN G. ENNIS, R.N., SUPERVISOR OF NURSES, DEPARTMENT OF PUBLIC SCHOOLS, PROVIDENCE, RHODE ISLAND

A Public Health Nurse in Rooming-In

ANTOINETTE HARRIS, R.N.

I AM A PUBLIC health nurse who was greatly impressed with rooming-in when it was just something I had heard and read about. Then I attended an institute in maternity nursing and decided that not only did I not want to miss the experience of working in such a program, but also that it would give me more of an opportunity to interest others if I had some practical experience. I was granted a leave of absence from my position as a staff nurse in a county health department in Southern California and I went to work and study in the Yale Rooming-in Project at the Grace-New Haven Community Hospital. I chose this because the project was planned as a family service and not as a way to overcome a nursing shortage.*

I hope very much that other nurses, and especially public health nurses, will appreciate the philosophy and teaching opportunities of rooming-in. Women all over the country are reading about rooming-in and natural childbirth and they ask questions. Nurses should be able to answer these questions.

Rooming-in in the Grace-New Haven Community Hospital is a family-centered environment providing for the mother and her newly born baby to be together in the postpartal period, an environment in which the father is included as much as possible. The rooming-in facilities consist of two units, each providing for four mothers and their babies. They are equipped and staffed separately from the maternity floor but the obstetrical procedures and technics are in harmony with those on the floor. (The pediatric procedures are, of course, at variance with the newborn nursery technics.) The patient unit consists of the usual hospital bed, overbed table, bedside stand, nursery crib, and small rocking chair. There are chairs and a small dining table for each group of four mothers. Each rooming-in unit has a nursery large enough to accommodate four babies.

Most public health nurses believe that maternity and infant care is the hub of public health work. It is our main chance for teaching positive health practices and for promoting good physical and mental health. Seemingly any program which provides good maternity and infant care plus a family educational program and an environment conducive to healthy family relationships would be welcomed by all health workers.

Rooming-in may often require some improvisation. In this hospital situation a homey atmosphere has been created with flowered drapes, a small dining table, and rocking chairs. No expensive or special equipment has been added. This informal background has made it easier to prepare the family for the transition from hospital to home. The instruction given to the parents in the unit is in accord with that given by the local visiting nurses so that the hospital teaching rein-

* The Yale Rooming-in Project, sponsored by the Department of Pediatrics and Department of Obstetrics and Gynecology of the Yale University School of Medicine, the Yale School of Nursing, and the administration of the Grace-New Haven Community Hospital, has received grants-in-aid from (1) Mead Johnson and Company (2) the George Davis Bivin Foundation, Inc. (3) the Field Foundation, Inc. (4) the National Institute of Mental Health of the National Institutes of Health, Public Health Service, Federal Security Agency.

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forces that given in the home, and vice versa. The equipment used is the type the mother can use at home, frequently the kind of improvised material public health nurses have demonstrated. My favorite example of this is the baby care tray. In rooming-in each mother has an ordinary two-shelf breadbox on her overbed table in which to keep supplies for breast feeding and bathing the baby and extra baby clothing. Here is a clean, separate, convenient container for baby supplies which is economical and practical and can be related to home use. Most important, the mother uses it.

LET US CONSIDER the mother in rooming-in. I think it is generally conceded that every woman completes a sizable job when she has a baby. Even a pregnancy terminated by a caesarian section represents nine months of preparation. Anyone observing a normal spontaneous labor is impressed by the tremendous amount of effort and energy expended. Therefore it seems to me that the mother has earned the right to have her baby with her from birth if she so desires. One has only to see the longing gaze of one mother being brought to rooming-in after a few days on the conventional type of obstetrical ward to be convinced. She can now relax and watch to her heart's content without wondering if the approaching footsteps belong to the nurse coming to whisk her baby back to the nursery. She literally feasts her eyes on the baby, as it is probably the first time she has seen her child lying in his crib. Perhaps as she watches he moves or sneezes or yawns, and she is thrilled.

This, of course, is one of the main advantages of the plan: she is able to observe her newborn infant completely. She learns what he sounds like when he's hungry, when diapers need changing, and all the little things that are new and frightening to the untaught mother and are a source of confidence to the comprehending one. She observes the care given by the nurse—holding, carrying, diapering and dressing, bathing, feeding, soothing, care of the umbilical cord, and perhaps care of a rash or a circumcision. The pediatrician examines the baby at the mother's side and all medical and nursing activities pertaining to baby are shared with the mother if she wishes.

There is a nurse around the clock for each group of four mothers and babies. Consequently, one of the best features of this rooming-in plan is that no mother is held responsible for the care of her baby. She assumes this care only when she wishes and is able to, and she does only as much as she wants. The nurse is basically responsible for the mothers and babies in her charge. In practice the only problem has been keeping the mothers from overdoing. Independence, rather than dependence, has been the fruit of teaching.

I was asked repeatedly by other nurses, doctors, and people outside the hospital whether the mothers get enough rest in rooming-in. One of the nurse's principal functions in rooming-in is perceptive observation. She must know when to suspect fatigue and how to relieve the mother subtly, without making her feel inadequate or regimented. The nurse must see that the mothers get their afternoon rest and that the environment is conducive to rest. It is also her responsibility to get the mothers to sleep early at night and reduce confusion and interruptions to the minimum. When this is done the mothers say they get more rest than on the obstetrical floor, where routines must be carried out at set times to accomplish the required tasks.

ALTHOUGH THE term ad lib is applicable to practically everything in rooming-in except visiting hours, medications, and mealtime—and sometimes even a mother's meal is kept warm until an infant feeding is accomplished—this expression is most commonly associated with the babies' feedings. All mothers wishing to breast feed are encouraged to do so and tutored. Decision to bottle feed is equally acceptable and mothers feeding their babies by bottle are also carefully supervised. Rooming-in is especially practical for the nursing mother and baby. When the baby is hungry he can be fed. The nurse who cares for the mother is responsible for the care of the mother's breasts, for giving instruction in the technic of feeding, and for seeing that the

baby is satisfied. Too many mothers cease breast feeding because of lack of professional interest and supervision. Several mothers who achieved success in nursing their second child expressed the feeling of having cheated their first child. Their usual explanation was that no one helped or encouraged them the first time, and too often they were discouraged. Many babies are not routinely hungry every four hours and in rooming-in they can be fed when hungry.

With the bottle-fed baby it is equally important that the mother be acquainted with her infant's feeding habits, with what the formula is, and with the proper technics of bottle feeding. Public health nurses receive frantic calls and often find upset mothers and babies because the mothers have not learned enough in the hospital about their babies' feeding habits. Is it normal for a baby to spit up? What should be done about hiccoughs? Is the formula disagreeing with the baby? Why does the baby have a rash? The mothers in rooming-in learn about these occurrences and accordingly know what to expect when they go home.

A remark frequently made to me was, "Well, it's fine for new mothers, but I don't think those who already have children would want it." Some people think that a mother of more than one child comes into the hospital for a rest after her delivery, and wants to get away from children.

I find this opinion completely groundless. During my experience at least half and probably more than half of the mothers in rooming-in were multiparae, and they were as ecstatic as or more so than the primiparae who can make no comparison. There was virtually 100 percent desire to return for future deliveries. One mother with a third child, speaking of her labor, delivery, and rooming-in, said, "If I thought it would be like this again I'd go right out and have another baby." Another mother of five who hadn't been sure she wanted rooming-in said, "If I had known it was like this I would have come the first day." And other mothers with eight or more children have loved it, some seeing their babies so young for the first time, and all amazed that their infants were individuals with such definite personalities from birth. When several years have elapsed since the mother had the previous child she may express anxiety about handling a tiny baby again. Such mothers feel they can adjust better on their return home because they know their babies well and have gained confidence and competence in infant care while at the hospital.

ANOTHER IMPORTANT feature of rooming-in is the group environment. New mothers learn from watching the more experienced ones. They lose some of their feelings of inadequacy when they see others equally baffled by the new experience. Just the pleasure of discussing an experience in common with someone else is helpful to many.

The dining table is a joy to the mothers after they are up and about, as mealtime assumes the aspects of a party. It is a wonderful group teaching opportunity. Perhaps the nurse is rocking a fussy baby while the mothers eat. She has the chance to discuss nutrition; not just for the mothers or the babies but for the whole family. Discussions of jealous siblings, toilet training, discipline, laundering baby clothes, sex education, and other points, arise so naturally that the teaching is easily given and received. Perhaps it is the feeling of belonging, not being alone, that is of value. The pediatrician may come along in time to have a cup of coffee with them in the morning and discuss questions of general interest. The mothers respond to this friendly interest and informal teaching. It is much easier for them to ask questions and express their anxieties in such a setting. One mother said, "As the number of mothers in rooming-in increases, more questions are asked and more answers given. The rooming-in mother, therefore, learns more about herself and her baby, and, having understanding, need not fear."

People are interested in the unit nursery. The baby is usually placed in the unit nursery at night; the mother knows he is near and can be brought to her when hungry. Yet she can rest better if she is not disturbed by the baby's every movement. A nursing mother, after her milk is fairly well established, may keep the baby with her all night. Any mother can keep

her infant with her continuously if she so desires, but she usually agrees to the nurse's recommendations. In this way all the mothers are disturbed as little as possible and yet ad lib feedings during the night are maintained. If the baby decides to sleep through the night the mother may do so also, as no schedule is enforced. It is interesting to note that the mothers are rarely disturbed by any but their own babies.

If a baby is fussy during a rest hour or if a mother seems to be getting tired the nursery is used, yet the baby is close enough to reassure the mother. Sometimes a mother expresses a feeling of guilt when the nurse suggests that her baby be placed in the nursery for a while, but she relaxes when she understands that the nursery was planned for such use.

Anyone familiar with nurseries and infants can tell feeding time by the insistent clamor which spreads throughout the nursery. Rooming-in rarely sounds like this, for a baby's requests are quickly answered, be it feeding, change of diapers, or love. Consequently the babies usually have an air of contentment. To be sure, some have their fussy periods; but the mothers not only observe this, but also learn the measures used to soothe and comfort them. A baby is never knowingly frustrated since there is always someone available to care for him. It is too early to tell what the farreaching psychological effects of this care will be, but certainly it seems more like what nature intended.

There have been no problems relating to contagion to date. The medical staff does not wear masks or gowns, but uses careful handwashing technic. Visitors wear gowns and wash their hands before handling the baby.

IF THE ROLE of the father as a parent is as important as everyone agrees it is it seems that he, too, should have a place in the baby's life from the very beginning. The joy of a father who has had to look at his baby through a window and at last in rooming-in is allowed to hold his child is indescribable. Some, at first, are terribly shy but once initiated are extremely cooperative about washing and gowning and are eager to participate in their infants' care. The nurse really has a chance to work with the fathers in rooming-in and, what is better, to teach the parents together. Often in public health nursing it is difficult to make home visits when the father is at home. Some fathers handle their infants more easily than the mothers do. Many learn the arts of feeding, dressing, and rocking the baby and are well prepared to assume some responsibilities for newborn care at home. Here again the group experience is important because the fathers gain confidence from each other and the initiate learns from the veteran.

Surely the family bond of affection is strengthened by the father's immediate feeling of parenthood and the opportunity to participate, rather than his feeling that he is an intruder and being treated as a constant source of contamination. As one mother wrote when describing her experience in rooming-in, "The family has already been established by the second or third day after the entry of a third and entirely new individual, whereas without rooming-in family feeling could be delayed weeks and sometimes disastrously forever."

Rooming-in has advantages for the nurse. For one thing it is more fun. Postpartal care is vitalized by the presence of the infant. Teaching, which I think is very definitely a part of good nursing care, is certainly made easier. In the conventional plan the nursery nurse knows very little about the mothers, the floor nurse little about the babies, and consequently teaching is often a haphazard affair. The mother directs her questions to numerous people and probably gets a variety of incomplete answers.

In rooming-in questions are easily asked and can be answered immediately. An entirely new field of possibilities arises with demonstration and group discussion. At present a "going-home" lecture given by a rooming-in pediatrician is the main group educational feature. It is an informal discussion and question and answer period held in the unit and all mothers attend at some time. Here the pediatrician reviews the development of the normal infant, anticipating questions which could arise after the family goes home and answering those asked by the group.

Although precautions must be taken for

mother and baby in rooming-in similar to those observed on the floor and in the nursery, there is a lack of rigidity in schedule that allows the nurse opportunity to individualize care. This interests her and develops her adaptability. The students observe teaching and see how every possible opportunity can be utilized to make a learning experience for the mothers and fathers.

IN CONCLUSION, I would like to say what has probably already been surmised, that this has been an extremely happy and satisfying experience. This was my first contact with patients who in the immediate postpartal period speak happily and expectantly of future progeny.

For one who has been doing public health nursing there is little adjustment to be made to the ad lib schedule or to the emphasis on teaching, and it is a great joy to find these being carried on in the hospital. It is my feeling that the spread of the rooming-in plan to more communities has been hampered mainly by a lack of understanding rather than by disagreement with the theory as properly practiced.

It is gratifying that in this plan the family not the mechanics of hospital routine is the chief concern. Certainly the plan is not presented as a perfect one. Continual experimentation goes on to improve the service and recommendations from the patients as well as staff are greatly appreciated. There are many possibilities in the teaching field yet to be explored.

But in rooming-in programs we see hospitals making an honest effort to combine the best of science in medicine and in human relationships by allowing mothers and fathers to have and to hold their new babies from the day of their birth.

I'm Eighty—So What!

I CELEBRATED MY eightieth birthday yesterday, and my friends showered me with cards and attention. Everyone said how well I look and how wonderful I am—at eighty. Why do they add that "at eighty"? What do they expect me to be like?

I feel the same as I ever did. I have the same interests. I'm still busy from dawn to dusk doing jobs that count. What if I do get tired a little more often and stop to rest? Isn't that good sense? Suppose I do eat smaller meals than those about me and weigh a little less than I used to? Isn't that according to the books? And even that pain that sometimes seems to persist—so what?

Should I sit in a chair and wear a shawl and allow old age to descend upon me? Well, I won't! I'll go and come as I always have, using the judgment God gave me, which has become seasoned and wiser, I trust, through the years.

Go ahead, tell me I'm wonderful! I love it, but please don't add "at eighty"!

—R.T.

ABSTRACTS . . .

CONGENITAL SYPHILIS: AN APPROACH TO THE PROBLEM VIA THE BIRTH CERTIFICATE

Since 1945 a specific question pertaining to prenatal blood tests has appeared on the South Carolina birth certificates. In 1946 the state passed a law requiring that every expectant mother have a blood test at the time of her first obstetric examination. Despite this during the first six months of 1950 thirty-four patients under four years of age were admitted to the rapid treatment center for treatment of congenital syphilis.

A study was made of more than 100,000 certificates filed for the years 1948, 1949, and 1950 in order to measure the completeness and accuracy of reporting prenatal blood tests. Preliminary study showed percentage of certificates on which prenatal blood testing of the mother was recorded in the entire state and in each county; comparison of percentage of certificates on which prenatal blood testing was recorded when the mother was attended at delivery by a physician in a hospital, by a physician at home, or by a midwife at home; comparison of percentage of certificates on which prenatal blood testing was recorded when the baby was born alive or was stillborn, born of white or colored parents, or born in a rural or urban locality; complete listing of individual birth certificates on which prenatal blood test was not recorded; and progress in percentage of birth certificates on which performance of prenatal blood test was recorded.

Information obtained from the preliminary study of the certificates filed for the year 1948 indicated that in 37 percent of the cases the prenatal blood test either was not performed or was not recorded. Certificates signed by physicians, both in hospitals and homes, showed a much higher percentage of delinquent certificates than those signed by midwives. Delinquent was used to describe those certificates on which the question pertaining to prenatal blood testing was either not answered or answered in the negative.

Copies of the prenatal blood test law were mailed during March 1949 to all county health departments and to all physicians whose names were listed at the state health department. Thereafter a marked decline in percentage of delinquent certificates from both physicians and midwives was seen. Later all of the county health departments and practically all of the hospitals were visited in an effort to obtain cooperation in carrying out control measures. A marked improvement has resulted in the percentage of prenatal blood tests being performed and in reporting them on the birth certificate.

The use of data obtained from birth certificates has proved to be one of the most effective single means of bringing the problem to the attention of physicians, midwives, and public health personnel.

From "Congenital Syphilis: An Approach to the Problem via the Birth Certificate" in *Journal of Venereal Disease Information*, August 1951.

CEREBRAL PALSY, A REVIEW: 1952

Cerebral palsy is a term used to designate any condition characterized by paralysis, weakness, incoordination, or aberration of motor function stemming from pathology in the motor control centers of the brain. The development of the existing lesions causing the manifest disease is assumed to occur during the developing stages of the central nervous system, or from conception to three years of age. In 1946 the incidence of cerebral palsy was seven per 100,000 of the general population, or one in every 215 births.

Research has shown that in 30 percent of the cases the damage occurs before birth, that 60 percent of the cases are injured at birth,

and that 10 percent receive injuries after birth. Approximately 15 percent of the babies born with cerebral palsy die during the first five years of life. Of the surviving infants 60 percent are considered educable.

Cerebral palsy falls into three main groups: (1) *Spastics,* which constitute 60 percent of the cases, have certain muscles which tend to tense and become immovable, especially when the patient attempts purposeful movements. (2) *Athetoids,* 35 percent of all cases, exhibit extraneous motion, especially when undertaking purposeful activity. Drooling and facial contortions are frequent accompaniments. (3) *Ataxias, tremors,* and *rigidities* are the third group. These manifest lack of balance, constant tremors, and clumsiness, and assume peculiar postures and positions.

There seems to be a direct correlation between mental deficiency and convulsions. Only 45 percent of the cases with convulsions are educable, whereas nearly 80 percent of the cases without convulsions are educable.

Two main factors causing cerebral palsy are anoxia of the fetal brain and hemorrhage—which may occur in the prenatal, natal, or postnatal periods—into brain substance. During the prenatal period some factors which are thought to be important are hereditary or germ plasm defect, x-ray irradiation of the fetus, certain infections in the mother during pregnancy, prenatal anoxia, prenatal hemorrhages, metabolic disturbances in the mother, blood incompatabilities, and possibly nutritional and vitamin deficiencies of the mother.

During the delivery period anoxia and cerebral hemorrhage may cause cerebral palsy. Recent studies have shown that many changes, originally called obstetrical or manipulative injuries, actually occur in cases of easy normal deliveries.

Postnatal factors, particularly infections affecting the brain tissue, such as meningitis, encephalitis, and postvaccination encephalitis, also cause cerebral palsy. Severe head injuries, suffocation, asphyxiation, and lead or arsenic poisoning may produce symptoms of cerebral palsy.

The most dramatic and rapid progress may eventually be made in the fields of drug therapy and neurosurgery. The neurological treatment of cerebral palsy is still experimental and at the present time only those who are extremely incapacitated are advised to have surgery.

From "Cerebral Palsy, A Review: 1952," by William J. Miller, M.D., *The Crippled Child,* February 1952.

STOMATITIS AND GINGIVITIS IN THE ADOLESCENT AND PREADOLESCENT

The prevalence of gingivitis in children varies from one part of the world to another; in the United States it is not high. Gingivitis of childhood is usually of a specific type rather than the nonspecific type, which is most common in adults. The specific types of gingivitis most frequently encountered are eruption gingivitis, pubertal gingivitis, and gingivitis caused by diphenylhydantoin sodium.

Eruption gingivitis is marginal in type and manifests itself around teeth in the process of eruption. The heavy gingival margin and partly erupted tooth prevent the normal excursion of food, and food debris is entrapped beneath the margin around the tooth, which produces marginal irritation. This type of gingivitis usually subsides when the teeth are fully erupted. The condition is treated by special brushing procedures which remove the impacted food and stimulate the gingival tissue.

Pubertal gingivitis is caused by a disturbed hormonal balance. This condition causes an increase in bulk of the gingival tissue. The treatment is entirely local, good oral hygiene and cleaning and polishing the teeth. When the hormonal balance is restored the tissues return to normal. This may take from a few months to two years.

Gingivitis caused by diphenylhydantoin sodium is a hyperplastic condition associated with the administration of this drug for the treatment of epilepsy and related nervous disorders. The process involves the entire gingiva but may be more noticeable in some locations than in others.

Herpetic stomatitis can be divided into two types, primary herpetic gingivostomatitis and secondary or recurrent herpetic stomatitis, because of the difference in clinical appearance

and treatment and the chronic character of the latter. Epidemics of herpetic stomatitis are often mistaken for Vincent's infection. There is evidence that it is highly communicable. Herpetic gingivostomatitis is caused by the herpes simplex virus. It usually occurs in young children but occasionally is observed in babies under one year and not infrequently in young people in the late teens. It is uncommon in adults.

The prodromal phase of primary herpetic gingivostomatitis is characterized by fever and lymphadenopathy which last for twenty-four to forty-eight hours. The fever usually subsides after the onset of the typical oral symptoms. During this stage the patient may develop an acidosis and become dehydrated. The ulcers appear and persist for five to ten days, then heal spontaneously without scarring. The disease varies in severity and may cause death. It is most severe in young infants. Because it is a communicable infection of self-limited type the disease does not respond to therapeutic measures of an abortive or curative character. Therefore treatment must be supportive and symptomatic.

Recurrent or secondary herpetic stomatitis is found in older patients who have been infected previously by the herpes virus. The first symptom is usually a sensation of swelling and burning in a localized region. This is followed shortly by the development of a vesicle that ruptures quickly and produces a shallow ulcer. The ulcer usually heals in from five to ten days without scarring. Like the primary lesions these are difficult to check and, in spite of therapy, run a specific course.

From "Stomatitis and Gingivitis in the Adolescent and Preadolescent" by Donald A. Kerr, D.D.S., M.S., *The Journal of the American Dental Association*, January 1952.

SMOKING AND ASTHMA

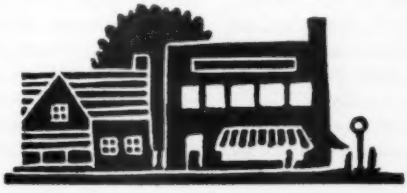
No patient who has asthma should smoke. Smoke of any type is irritating, not soothing to mucous membranes. Smoking induces cough, bronchitis, and bronchospasm, which are nature's warnings to avoid or expel the irritating effects of smoke. Any temporary benefit that patients derive from smoking so-called asthma cigarettes or burning powders which contain stramonium or nitrates is nullified by the deleterious effect of the smoke itself, which aggravates the patients' bronchitis. All patients with asthma have some degree of bronchitis.

No patient with asthma should irritate his inflamed membranes with smoke, yet high-pressure salesmanship is being exerted to encourage smoking. Recognizing the irritating effects of smoking, some tobacco companies now supply built-in filters in their cigarettes, or treat them with menthol to allay burning of the tongue and throat. If there were no irritation there would be no market for filters and other devices such as the various types of holders.

Some asthma patients have been advised to continue smoking because cutaneous tests with tobacco antigen give negative results. The mere fact that results of tests for allergy to tobacco products are negative is no criterion that the asthma patient can tolerate smoking.

It should be axiomatic that asthma patients should not smoke.

From "Smoking and Asthma" by G. A. Peters, M.D., L. E. Prickman, M.D., G. A. Koelsche, M.D., and H. M. Carryer, M.D. *Proceedings of the Staff Meetings of the Mayo Clinic*, August 13, 1952.



NEW BOOKS
And Other Publications

THE HUMAN GROUP

George C. Homans. New York, Harcourt, Brace and Company. 1950. 484 p. $6.

In the author's eyes there is still only one sufficient reason for studying the group: the sheer beauty of the subject and the delight in bringing out the formal relationships that lie within the apparent confusion of everyday behavior.

The group has long been regarded as a central subject matter of sociology but there has been surprisingly little systematic social theory aimed directly at this elementary unit. Homans now devotes a long book to the subject and has erected a series of hypotheses, which, he hopes, if they are further empiricized, will permit a more rigorous discipline to be established. The book then is another attempt in social science to proceed postulationally, and its import is presaged in a foreword by the illustrious publicist, Bernard DeVoto, and in an introduction by the renowned social theorist, Robert K. Merton.

Once the system of concepts is developed, and their systematic analytic values are remarked, the book attempts to test them against such seemingly diverse groups as the Bank Wiring Observation Room aggregation described in several studies of the Harvard Graduate School of Business Administration made by Elton Mayo and his associates, William Foote Whyte's gang from *Street Corner Society,* and the Polynesian family in Tikopia described in several works of the British anthropologist, Raymond Firth. Sandwiched between the excellent descriptive material (which frequently is superior to the original) Homans develops chapters in which his theoretical explanatory concepts are related to the material and further hypotheses are developed.

No attempt will be made here to digest this system but it is, to say the least, revelatory and appears to be firmly backed up with analogies to thermodynamics and other physical and mathematical constructs. After developing material relating to the problem of the one and the many in treating the person and culture and demonstrating the absurdity, from Homans' viewpoint, of any system of one-way determinism in that area, a case study of a socially disintegrating New England town is presented, followed by one of social conflict in an expanding industrial concern, and both are analyzed in the light of previous concepts and hypotheses. A chapter is devoted to the job of the leader; another to a summary; and finally (and somewhat nostalgically) a chapter is concerned with the role of groups in the growth of civilization and in contemporary democracy.

The book contains contributions of several sorts. It is modest in most of its pretensions. It makes no claims that more than hypotheses are presented. It focuses renewed attention in social theory on the group. The concepts and hypotheses are arranged in logical order and several insights into group functions are achieved. The case studies are excellent, extremely readable, and indicate that, in so far as social anthropology is not primarily the study of culture but rather of social relations

and interaction, sociology is only arbitrarily a different discipline from anthropology. Conceivably, if the terminology were to receive the same kind of acceptance that Ralph Linton's *Study of Man* has had in the past fifteen years, the book may have a considerable impact on professional social science. As it stands it may well focus greater attention on small groups than has been fashionable in the past. It could become helpful as a theoretical stimulant to occupational segments of the population which do practical community work, such as nurses, personnel men, social workers, and the like.

From a more critical viewpoint the book is occasionally repetitive, ostensibly, I presume, with the object of more thorough reader comprehension, and hence, on occasion, carries pedantic "dear reader" overtones. There is an amazing insularity of reference. Cooley is noted once; Chester Barnard more than a dozen times. The conceptual frame is equally secular. What another sociologist might regard as central core concepts in the analysis of the group, those of the "self" and of the "symbol," are, if used at all, incidental or hidden under "norms" and "sentiments." Functional interdependence is the theme song. Determinism is derided, except the manifest particularism of mutual dependence, the mutality of cause and effect of Homans' concepts, and, except briefly, there is no pervasive evolutionary focus. Leadership and following "orders" are central concerns. The meaninglessness of "leadership" under a culturological web of forces not considered as such is dismissed in effect by a restatement of Durkheim.

Leadership may be awfully important if one views the beehive (the group) from the perspective of the queen bee; unimportant from the perspective of unfolding biologic process. Of course, as Homans might say, men are not bees! There is awareness that functionalism may tend to justify what is, and (without too much consciousness) to make it what ought to be, but the limitations to conscious social action even in a "small group," as so clearly exposited by Leslie A. White in *The Science of Culture* and inferable from Durkheim, are not manifestly a part of the author's underlying value system or of his analysis. Perhaps these "faults" lie in the sociopsychological rather than the culturological orientations of the book. But in so far as the book is as much a treatise on the things which environ and control groups (even though this is not the author's specific intention) and to the extent that the analysis focuses attention not on behavior itself but on the conditions for behavior the book contributes to sociological theory.

Sociology is frequently derided as an elaboration of the obvious. There is much in the book which some might regard to be "platitudinous sociology," as when the author introduces his chapter on the family in Tikopia thus: "Marriage is the most successful of human institutions," but Homans repeatedly claims that he is not above examining the obvious. Yet there is much here that transcends the obvious and gives insight and systematic hypotheses to sociocultural phenomena. And, as Homans points out "If a system of hypotheses is to account for and ultimately to predict the actual behavior of a group, the hypotheses themselves are not enough. We must be able to assign values to the elements entering the hypotheses. . . . In this book we have hardly begun to solve this problem." Despite this limitation a very real contribution has been made by this attempt at the systematic formulation of the small group phenomenon.

—Norman D. Humphrey, Ph.D., *Associate Professor of Sociology, Wayne University.*

DISEASES IN OLD AGE

Robert T. Monroe, M.D. Cambridge, Harvard University Press. 1951. 407 p. $5.

Another book has been added to the rapidly growing list of publications dealing with our older population. And it is a good one. Dr. Monroe has contributed a unique achievement. He has taken statistical material and made of it a book which is thoroughly alive, exciting, and informative. He has recorded a detailed study of the medical records of more than 7,000 patients over sixty-one years of age admitted to the Peter Bent Brigham Hospital between 1913 and 1940. The findings have

been definitely recorded and clarified by the use of numerous tables. Generously sprinkled through each chapter are the author's interpretations, philosophical comments, and miscellaneous illuminations, gathered from his wide experience in the field of geriatrics. They add tremendously to the readability of the book and to its practical usability.

The introductory chapter gives general features of the group of people under study. There are chapters dealing with specific subjects such as the nervous system and the cardiovascular system. Some popular assumptions about older patients are exploded. For example, the belief that coronary disease is more common in men than in women was found to be untrue in this series—in fact, the reverse was found to be true. At the end of the book there are a summary of medical findings and a long chapter on community resources essential for old people, for Dr. Monroe believes that one of the basic principles of geriatrics is that "it must know the effects of social, emotional, and economic forces on aging individuals and find the resources to cope with them."

The public health nurse working with individuals in their own homes and communities, the nurse in the clinic, the nurse at the patient's hospital bedside—all will find much in this book that is of interest and can be put to use.

—KATHLEEN NEWTON, R.N., *Cornell University-New York Hospital School of Nursing.*

THE OTHER CHILD

Richard S. Lewis with Alfred A. Strauss and Laura E. Lehtinen. New York, Grune and Stratton. 1951. 108 p. $2.50.

Parents, nurses, teachers, and friends of brain-injured children will find this book a satisfying explanation of the "other child's" needs and abilities. The real feeling with which Mr. Lewis treats the problems will find a ready welcome for the book in the hearts of his readers. Selection of the phrase "other child" to identify the person about whom he is writing is but one manifestation of the warm and personal manner that prevails in the treatment of this subject.

Parents of the "other child" will find much of the book reassuring. The behavior of the brain-injured child becomes more understandable because it is related to the cause, the injury of the brain itself. There are practical suggestions for coping with problems of everyday living. Attitudes and the role of the parent are particularly emphasized. Emotional reactions are accepted and analyzed for the lay person. There is a real need for an educational method for the "other child." What he can learn is difficult to appraise and must be measured in terms of educational effort and the extent of the brain injury.

The combination of the deep feeling and vivid writing of Richard Lewis and the objectivity and specialized knowledge of Dr. Strauss and Laura E. Lehtinen makes a contribution to any reader's understanding of the brain-injured child.

—MARY M. REDMOND, R.N., *Assistant Professor of Nursing, Director of Program in Advanced Psychiatric Nursing, The Catholic University of America.*

PREPARING TOMORROW'S NURSES

Elizabeth Ogg. New York, Public Affairs Committee in Cooperation with National League for Nursing. 1952. 25c.

This highly readable pamphlet deals with nursing care, its availability and quality, and how both can be improved. Nurses have long given much thought to this subject and have concerned themselves actively with it. The public at large, as consumers of nursing service, could do well to find out what recommendations and plans are being made to bring about improvements in the education of nurses, how practical these are, and what the individual can do to further them.

Miss Ogg's pamphlet, although of interest to nurses, is directed primarily to the layman. It is written in nontechnical, understandable language and sets forth clearly today's nursing picture. Anyone who has been ill and needed a nurse at home or in a hospital knows something about the nursing shortage. Certainly administrators and members of hospital and nursing boards and committees are keenly aware of this dilemma. The reason for the need for more nurses may be found in Preparing Tomorrow's Nurses, and ways of sup-

plementing the work of available nurses with auxiliary personnel are described.

Many may ask why nurses cannot be trained as they have been for many years in hospital schools of nursing, why these schools should be accredited, and what place the degree course in collegiate schools of nursing should have in the modern education of nurses. Miss Ogg answers these questions by first outlining the many changes that have come about in the responsibilities delegated to the nurse and then by stressing the fact that with modern developments in medical science the role of the nurse has become an increasingly complex one. She points out the need for the development of leadership qualities if the nurse is to be the head of a team of auxiliary personnel, and clearly explains why new and more thorough training is vital in the fields of supervision, administration, and education. Nursing schools are at the crossroads, she says. The old methods are not good enough to prepare the nurse to shoulder the heavy responsibilities she is faced with today, whether she works in the hospital, in public health organizations, in industry, or in the home.

The author goes on to describe the new methods of education, telling of past weaknesses and where these may be strengthened, and of new objectives. Many nursing schools throughout the country are working toward these objectives. Some have reached them. All need the help and understanding of the community.

The community needs the nurse. She cares for us and our families. It is important to us to see she gets the best preparation possible for this service. Preparing Tomorrow's Nurses tells why and how. It should be a "must" on everyone's reading list.

—Mrs. Carroll J. Dickson, *Chairman, Education Committee, Brooklyn Visiting Nurse Association, and Chairman of the Council for Red Hook-Gowanus Community Nursing Service.*

GENERAL

Measurement and Evaluation in Physical, Health, and Recreation Education. Leonard A. Larson, Ph.D., and Rachael Dunaven Yocom, Ph.D. St. Louis, the C. V. Mosby Company. 1951. 507 p. $7.50. This text should aid in the improvement of measurement and evaluation programs so that practices and interpretation of technics used to gain information about the product and process of education may be developed in the light of the total purpose of education, as partially accomplished through the programs of physical education, health education, and recreation. Both the administration of tests and the statistical calculations discussed are simplified by pictorial illustration and step-by-step directions. May be used as a text for both elementary and advanced courses in measurement and evaluation and as a reference on the subject.

Careers in Service to the Handicapped. Published by the National Foundation for Infantile Paralysis and the National Society for Crippled Children and Adults with the cooperation of the Federal Security Agency. 1952. 53 p. 50c. Available from the National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3. In this booklet the qualifications, duties, opportunities, and rewards of the professional members of the rehabilitation team in services for handicapped children and adults are presented and the related fields of occupational therapy, physical therapy, special education, and speech and hearing therapy are discussed and compared.

Educational Exhibits, How to Prepare and Use Them. Agriculture Handbook 32. H. W. Gilbertson. Washington 25, D. C., U. S. Government Printing Office. 1951. 41 p. 25c. This handbook tells how to prepare and use exhibits to present information quickly and convincingly. Technics of drawing attention, holding interest, and motivating action are described, and materials, arrangements, mechanical devices, and types of exhibits for various purposes are discussed. Photographs of exhibits are provided to supplement text explanations.

After Teen-Agers Quit School—Seven Community Programs Help Would-Be Workers. Bulletin 150. Bureau of Labor Standards, U. S. Department of Labor. Washington 25, D. C., U. S. Government Printing Office. 1952. 30 p. 25c. The story of what seven cities did for boys and girls who, after dropping out of school, were baffled by the problem of finding and holding jobs. This booklet describes the programs that were developed for helping these teen-agers find the right jobs.

Getting Ready to Retire. Kathryn Close. New York, Public Affairs Committee, Inc. 1952. 23 p. 25c; special quantity rates.

Blakiston's Illustrated Pocket Medical Dictionary. Normand L. Hoerr, M.D., and Arthur Osol, Ph.D., editors, and others. New York, the Blakiston Company. 1952. 1,032 p. $3.25; thumb-indexed $3.75.

ZOOLOGY. Alfred M. Elliott. New York, Appleton-Century-Crofts, Inc. 1952. 719 p. $6.

LIVING AGENTS OF DISEASE. James T. Culbertson and M. Cordelia Cowan. New York, G. P. Putnam's Sons. 1952. 624 p. $5.50.

VOCATIONAL SERVICES FOR PSYCHIATRIC CLINIC PATIENTS. Thomas A. C. Rennie, M.D., and Mary F. Bozeman. Cambridge, Harvard University Press. 1952. 100 p. $1.25.

HANDBOOK FOR GROUP LEADERS. Ann Curphey Brown and Sally Brown Geis. New York, Woman's Press. 1952. 212 p. $3. Contains information on program resources and technics for leadership. Practical advice is given on how to prepare a constitution, how to work with committees, how to conduct a meeting, and how to get publicity. Of great assistance to those who work with community groups.

HOW TO WORK WITH GROUPS. Audrey and Harley Trecker. New York, Woman's Press. 1952. 167 p. $3. Outlines the responsibilities of leadership in an organized group, giving pointers on how to recruit members, develop committees, plan successful programs, conduct business meetings, take minutes, secure publicity, raise funds. A concise discussion of parliamentary law is included.

HOW TO PREPARE A SPEECH. Ivan Gerould Grimshaw. New York, Woman's Press. 1952. 105 p. $2.50. Written to help those called upon to say a few well chosen words before a neighborhood group. Information is given on how to gather material, how to adapt the talk to the audience involved, how to deliver the speech with assurance and in a relaxed manner. An annotated guide is included on available reference material.

PUBLIC HEALTH

ESSENTIALS OF PUBLIC HEALTH. William P. Shepard, M.D., with the collaboration of Charles Edward Smith, M.D., Rodney Rau Beard, M.D., and Leon Benedict Reynolds, Sc.D. Philadelphia, J. B. Lippincott Company. 2nd edition. 1952. 581 p. $6.50. This book will be particularly useful to the physician in private practice and to all professional people interested in health problems of the community. This edition includes a new chapter on public health nursing. The functions of various health agencies are discussed and presentday conditions, their background, and the progress made by public health workers in conjunction with the medical profession are described. It is written in a simple clear style and the references listed at the end of each chapter serve as valuable guides to further study on specific phases of public health activities.

HANDBOOK OF PHARMACOLOGY FOR NURSES. Robert Shestack, Ph.G.R.P., Philadelphia, W. B. Saunders Company. 1952. 171 p. $3.

THE ENCYCLOPEDIA OF NURSING. Lucile Petry, editor. Philadelphia, W. B. Saunders Company. 1952. 1011 p. $4.75. This is a first—the first encyclopedia derived not from some other work but planned and published for its instructive and reference value. It is not a dictionary of medical terms but a description of technical details, methods, and the rationale of nursing. Effort has been made to incorporate the latest information and the newest concepts in the field. Emphasis is on nursing and the application of general and scientific terms to nursing methods and nursing education. Clinical terminology is included as well as terminology in the social sciences used in nursing, in addition to biographic notes on important medical and nursing figures and notes on the history of nursing organizations.

NEWS AND VIEWS

PREPAYMENT PLAN FOR NURSING

An interesting and important experiment in a prepayment plan for nursing care is scheduled to start this fall. The Associated Hospital Service of New York, a Blue Cross plan, has entered into a contract with the Visiting Nurse Service of New York, the Visiting Nurse Association of Brooklyn, and the Visiting Nurse Association of New Rochelle to provide nursing care to Blue Cross subscribers who have been hospitalized at Lenox Hill, Brooklyn, and New Rochelle hospitals and who require parttime nursing care after discharge. A study to last one or two years will be carried on to find out whether a patient's hospital stay can be shortened by providing such follow-up service, whether subscribers want this service, whether hospitals will find it helpful, and whether Blue Cross will gain or lose.

The VNSNY has released a supervisor, Maria Phaneuf, to work as coordinator with the administrators of the three hospitals and the three vnas.

COLORADO INSTITUTE ON INTERPERSONAL RELATIONSHIPS

About thirty-five public health nurses from rural services throughout Colorado met together in Denver for a three-day institute on mental health. The nurses were divided into small groups according to their common professional interests, such as nurses working alone, those in organized areas, and supervisors and consultants.

The faculty staff consisted of psychiatrists, psychiatric and medical social service directors, mental health nursing consultants, and psychiatric nursing instructors.

Some of the subjects discussed were the meaning of authority; the relationship between staff and faculty; attitudes in working with patients; the nurse's feelings about other cultures, about other professional agencies, and about certain environmental conditions; the need to prove oneself. The absence of reference material, exhibits, notebooks, et cetera, at first created some anxiety, but little by little a more comfortable feeling developed and a richer understanding sprang up between staff nurses and supervisors.

The institute was sponsored by the Public Health Nursing Section, Colorado State Department of Public Health. The cost of transportation and lodging was paid through funds of the Mental Health Section, the participants paying for their meals.

BOUND VOLUMES OF MAGAZINE AVAILABLE

Bound volumes of PUBLIC HEALTH NURSING for 1937, 1938, and 1940 are available and may be purchased at five dollars each volume from the Massachusetts Memorial Hospitals. If interested, please write to the librarian, Miss Barbara Altman, at 750 Harrison Avenue, Boston 18, Massachusetts.

NEW PUBLICATIONS

First of its kind is a booklet, Psychological Problems of Cerebral Palsy, just published by the National Society for Crippled Children and Adults. The booklet brings together the papers of outstanding psychologists who participated in the first symposium held to consider exclusively the psychological aspects of cerebral palsy. Write to the society at 11 South La Salle Street, Chicago 3, for copies. Price $1.25.

Two more Children's Bureau publications have come out of the findings of the Midcentury White House Conference on Children and Youth: Emotional Problems Associated with Handicapping Conditions in Children; and Children with Impaired Hearing: an Audiological Perspective. The first pamphlet describes some of the emotional problems

faced by handicapped children and discusses how health personnel can work with parents and communities to help these children develop to their fullest capacity.

The hearing pamphlet is a paper by William G. Hardy of Johns Hopkins University, in which he points out what has happened in the past ten or fifteen years to motivate changes in the approach to the problems of children with impaired hearing.

Single copies of these pamphlets may be obtained free from the Children's Bureau, Federal Security Agency, Washington 25, D. C. Copies may also be purchased from the U. S. Government Printing Office, Washington 25, D. C. Price 15 cents and 20 cents respectively.

Also available from the Children's Bureau, free of charge, is Better Health for School-Age Children. This publication grew out of a recently held meeting of the Committee on the School-Age Child, which comprises representatives of the Office of Education, Public Health Service, and Children's Bureau. Through this committee these three offices of the Federal Security Agency are working together to help build better health for all school-age children.

RESEARCH IN NURSING

A grant of $100,000 has been made by the Rockefeller Foundation to the Division of Nursing Education, Teachers College, Columbia University, to establish a center for the administration of a program of research, experimentation, and field service in nursing education. The center will undertake a five-year study of the major problems in nursing service and nursing education in the United States.

The center's program will be based on five main activities. It will conduct studies and experiments to determine the functions of nursing and the best use of nursing personnel and, when necessary, redesign the courses for inservice, practical, technical, basic professional, and graduate nursing education; provide consultant service to selected nursing schools and agencies; organize field studies on problems of individual schools and agencies; distribute research findings and field experience information that may improve nursing education and service; contribute to the training of a selected group of future leaders in nursing education and service.

NEW PUBLICATION

Guide for the Development of Libraries in Schools of Nursing. Prepared by the Committee on Guides for the Development of Libraries in Schools of Nursing of the National League of Nursing Education. Includes information on selection, arrangement, and maintenance of the library collection; cataloging, acquisition, and withdrawal of publications, records and reports, periodical indexes, and public relations; the functions, qualifications, and policies relating to the library staff, equipment and materials needed for proper maintenance; library budget; and a bibliography. Mimeographed. Available from National League for Nursing, 2 Park Avenue, New York 16. 13 pages. Price 30 cents.

ABOUT PEOPLE YOU KNOW

Annabelle Petersen, associated with the American Red Cross since 1920, retired late in June. She has had many assignments and served last as assistant to the national director of nursing services, ARC. Miss Petersen was recently elected treasurer, ANA, and thus will not be leaving the nursing world completely. . . . The ARC announces also the retirement of *Mary Hawthorne*, who has been nursing supervisor of Red Cross employee health service. . . . *Geraldine A. Busse*, formerly a district supervisory nurse, has returned to the Iowa Department of Health as nurse consultant in mental health. Miss Busse took her mental health study at the University of Minnesota.

The USPHS announces the appointment of *Dr. James R. Shaw* as chief, Division of Hospitals, Public Health Service, FSA. Dr. Shaw succeeds *Dr. G. Halsey Hunt*, who was recently named associate chief, Bureau of Medical Services. . . . *Myrtle Irene Brown* has been appointed assistant professor in public health administration, Johns Hopkins University School of Hygiene and Public Health, where she will participate in the educational and research programs of the Division of Maternal and Child Health. Miss Brown was in India as a WHO nurse consultant in 1949-1950, and recently was with the Wayne County (Michigan) Health Department.

Anna M. Fisher has joined the Point Four mission in El Salvador as consultant in nursing. This program is under the Division of Health, Welfare, and Housing, Institute of Inter-American Affairs.

NATIONAL AIR RAID WARNING SYSTEM

Operation of the civil air raid warning system in the United States was transferred from the U. S. Air Force to the Federal Civil Defense Administration on June 1. FCDA is now responsible for the dissemination of warning of enemy air attacks to the civilian population. Each of the air defense control centers throughout the country will be manned twenty-four hours a day.

FROM HEADQUARTERS

NLN MEMBERSHIP NOTE

The 1953 NLN membership drive is under way. All who are concerned in improving and promoting public health nursing services—nurses, public health administrators, members of allied professions, and board and committee members—are invited to join the NLN and to take part in the activities of the Department of Public Health Nursing.

Of course, if you were an NOPHN member in good standing when the NLN was formed your membership was automatically transferred to the NLN. New individual members are asked to join the NLN directly until state leagues for nursing are established.

Application forms for both individual and agency members are available at state nursing meetings and from the Membership Secretary, National League for Nursing, 2 Park Avenue, New York 16. New members enrolling on October 1, 1952, and throughout the remainder of 1952 are granted membership through 1953.

● The New York University Institute of Physical Medicine and Rehabilitation is offering another series of three-week seminars in physical rehabilitation methods for nurses, starting December 1, 1952, March 2, and May 18, 1953. Tuition is $60. The course is planned for graduate nurses working within the hospital or in the public health fields. The philosophy and principles can be applied by the staff nurse in patient care, by the supervisor in orienting her department toward rehabilitation, and by the instructor in nursing arts or clinical nursing.

For application blanks and additional information write to Miss Edith Buchwald, Institute of Physical Medicine and Rehabilitation, 400 East 34 Street, New York 16, N. Y.

● The New Jersey Division of the American Cancer Society will hold its second annual institute for nurses on Thursday, November 13, 1952, at Princeton. Attendance is limited to 1,000 and the last day for registration is November 6. The program is being arranged by Dr. Joseph I. Echikson, chairman of the Professional Information Committee, New Jersey Division, and a committee of nurses including Wilkie Hughes, Rose Coyle, Margaret Maskrey, Elise Cuff, Nellie Winey, and Margaret Sharp.

● The University of Pittsburgh School of Nursing will offer a workshop for industrial nurses from November 10 to November 21, 1952. The workshop will be devoted to a study of the contribution of the industrial nurse to the total industrial health program. Consultants from special fields will be available and supervised field trips will be arranged.

The workshop may be taken for credit if the student wishes this. Tuition is $37.50. Immediate registration is advisable.

For applications and other information write to Miss Glenna G. Walter, Director, Program for Industrial Nurses, School of Nursing, University of Pittsburgh, Pittsburgh 13, Pennsylvania.

American Journal of Nursing for October

The Significance of Interpersonal Relationships . . . Sidney Berengarten

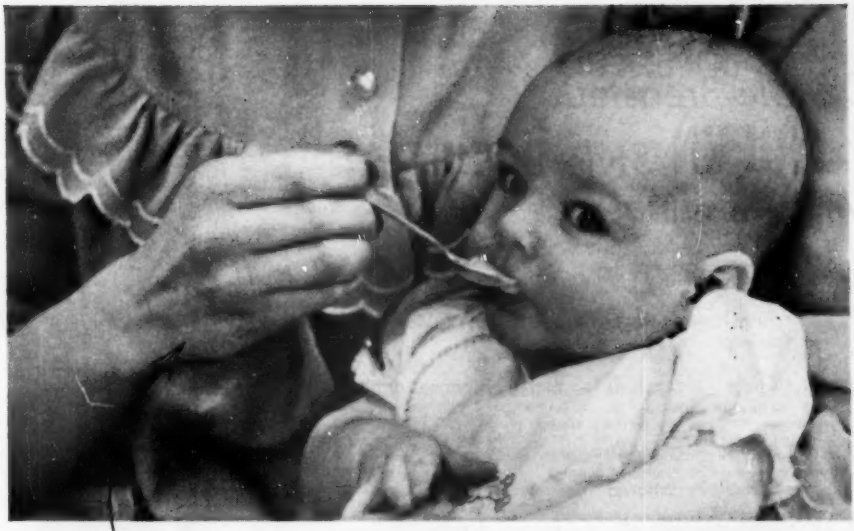
Nursing School in Pakistan . . . Elizabeth Heerema, R.N.

The Child with Cerebral Palsy and the Nurse . . . Mary Stewart, R.N.

Hypertension, Arteriosclerosis, and Diet . . . Andrew W. Contratto, M.D.

Supervision of Nonprofessional Personnel . . . Mary W. Northrop

The Public Health Nurse as a Faculty Member . . . Grace Eckelberry, R.N.



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- Produce is grown in tested soils . . . under constant supervision . . . with sprays and fertilizers specially suited to baby foods.
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ASK FOR FREE PUBLIC HEALTH STYLE CATALOG

The Vital Story of Bread Enrichment

by Science Writer

1951 marked the Tenth Anniversary of the white bread and flour enrichment program in the United States. This ten-year experience proved the success of a program which used the combined talents of bakers and millers, nutritionists and physicians, diet experts and chemists . . . an inspiring example of how a good food is made better in the American way of free initiative and cooperating effort. In fact, the value of enrichment is so highly regarded that over one-half of our states and several territories have already passed laws making its use mandatory in all white bread and family white flour sold commercially in those areas. The Council on Food and Nutrition of the American Medical Association is on record as supporting enrichment as is the Food and Nutrition Board of the National Research Council.

"It is encouraging and gratifying to compare the health of the American people today with what it was 10 years ago," said Elmer L. Henderson, M.D., President of the American Medical Association.

"And I do not think it is too much to say that a very important part of the more buoyant health and the increased mental and physical vigor the American people enjoy today can be directly credited to the enrichment of bread with essential vitamins and minerals."

The skeptics, "food faddists," and others who demanded proof that enrichment benefited the public health were again answered emphatically when the dramatic results of a long term nutritional study in Newfoundland were made public.

What is enrichment? Before answering that question, let's note two indisputable facts.

Fact No. 1—Americans generally want beautifully fine, white bread.

Fact No. 2—In milling and processing wheat to get this white flour which the public demands, some nutritional values are unavoidably lost.

Enrichment is the process which restores the following vital vitamin and mineral values to the finished white bread or milled white flour: thiamine, riboflavin, niacin, and iron. Calcium and vitamin D may also be added as optional ingredients.

Many vitamins have been isolated in the laboratory so that the pure substance could be studied. Brilliant chemists have "built" duplicates of them by complex processes. They are identical chemically and biologically with those existing naturally. A vitamin is a vitamin regardless of its source, just as salt is salt whether it comes from a mine or is evaporated from the sea. Large-scale manufacturing efficiency permits vitamins to be sold at a lower cost than if they were extracted from natural sources."

These are the vitamin and mineral factors which are used in white bread and flour enrichment:

Thiamine—also called vitamin B_1. This vitamin helps to build physical and mental health. It is essential for normal appetite, intestinal activity and sound nerves.

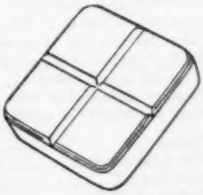
Riboflavin—also called vitamin B_2. This vitamin helps to keep body tissues healthy and to maintain proper function of the eyes. It is essential for growth.

Niacin—another "B" vitamin, is needed for healthy body tissues. Its use in the American diet has done much to make a serious disease called pellagra disappear.

Iron—is the mineral used in enrichment. It is essential for making good, red blood and preventing nutritional anemia.

It is possible to enrich bread by two basic methods. One involves the use of flour which is enriched at the mill in accordance with the Federal Definitions and Standards of Identity. The other method, which is widely used by bakers, merely requires the addition of a small wafer.

The Hoffmann-La Roche people manufacture vitamins literally by the tons. To do this they must use amazingly complex processes with scientific production controls and the latest equipment, which can fill a building a city block square and many stories high. Roche combines the enriching ingredients in a form known as the Square wafer. It is distributed by leading yeast company salesmen throughout the United States.



The Square wafer for bread enrichment measures 1¼ inches across. It is ¼ of an inch thick. Yet it contains enough thiamine, riboflavin, niacin and iron to enrich 100 pounds of flour so that the resulting product will meet the requirements of all State enrichment laws with an ample safety margin. The formula is as recommended by the Scientific Advisory Committee of the American Institute of Baking.

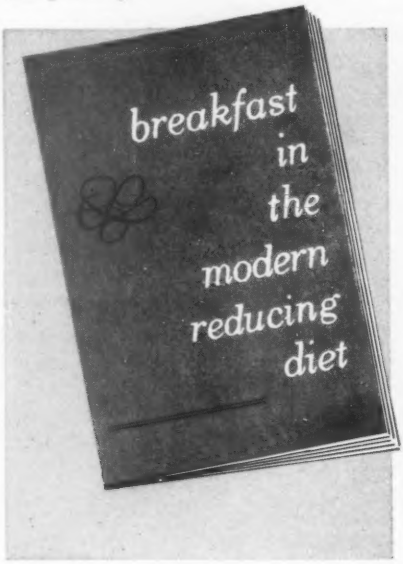
Here is a suggested statement for white bread labels or wrappers which has the approval of the A.B.A. and the A.I.B.:

8 ounces of this enriched bread supplies you with at least the following amounts of your minimum daily requirements for these essential food substances: Thiamine (Vitamin B_1) 55%; Riboflavin (Vitamin B_2) 17.5%; Niacin (another "B" Vitamin) 5 milligrams; Iron 40%.

This information is published by the Vitamin Division, Hoffmann-La Roche Inc., Nutley 10, New Jersey. Reprints of this entire article as presented to the baking industry are available on request.

In weight control breakfast is important

MEMO—*this booklet is based on current research and is edited by a leading authority.*



It is estimated that twenty-five million people in the United States are overweight. The leaders in the medical profession and in the public health field consider this a serious health problem and are engaged in a corrective educational program.

Included in this program is new recognition of the importance of the morning meal in reducing diets. Recent scientific studies have demonstrated that a good breakfast is the key to any successful reducing diet. Yet over the past years faddist and "high-fashion" reducing diets have contributed to the neglect of breakfast, which science now reports was harmful.

As a contribution to the nation-wide weight control program, the Cereal Institute has prepared a booklet titled, "Breakfast in the Modern Reducing Diet." It is available to you free on your letter of request. If you would like 25 free copies for your own use and distribution please so state in your letter and we will send them immediately.

The subject matter in this booklet is based on current scientific and library research and is edited by a leading authority. It covers the weight control problem in an interesting, sound, and true manner and is attractively illustrated. Write for your free copy today.

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STAFF NURSES: Generalized public health nursing in established county health department on Long Island; beginning salary $3,840; $5,040 salary reached in 6 annual increments of $200; personal car required; accessible to New York City; 5-day week; cumulative sick leave; Civil Service benefits. Write to Philip J. Rafle, M.D., Commissioner, Suffolk County Department of Health, Riverhead, New York.

PUBLIC HEALTH NURSE: generalized program in city health department; salary $295 to $345; 5-day week; paid vacation; sick leave; retirement; car furnished; registration in California as RN and PHN and driver's license required. For further details write to Fannie Warncke, Director of Nursing, City Hall, Oakland, California.

DIRECTOR: Public health nursing, city department of health; generalized public health nursing program; 22-nurse staff, 4 supervisors; good personnel policies. Write to Dr. J. J. Day, Medical Officer of Health, Transportation Building, 48 Rideau Street, Ottawa, Canada.

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QUALIFIED NURSE: Generalized public health nursing program; salary determined by education, experience; salary increments; Social Security; good personnel policies; suburban location, 13 miles from New York; interview by appointment. Write to Miss Lillian A. Ford, Assistant Director, Visiting Nurse Association of the Oranges and Maplewood, 439 Main Street, Orange, New Jersey.

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PUBLIC HEALTH NURSES: General rural program; salary, public health nurses, $2,852-$3,560, graduate nurses as assistant PHNs, $2,540-$2,972; travel allowance 6c a mile; 5-day week, vacation, sick leave, and retirement benefits. Write to Mrs. Earle W. Gibbs, State Health Department, Richmond, Virginia.

STAFF NURSE: 5-nurse staff, generalized urban program; minimum public health qualifications; 5-day week, one month vacation, 2 weeks sick leave, retirement plan; community a resort center, population 75,000. Write to Bobbie Loring, R.N., Director, Galveston Public Health Nursing Service, 4127 Avenue I, Galveston, Texas.

SUPERVISOR AND STAFF NURSES: Immediate appointment on provisional basis; starting salary, supervisor, $3,300; staff, $2,700; 37½-hour week, 24 days sick leave, 18 days vacation; retirement plan. Write to Mrs. Anna Amann, Director, Bureau of Public Health Nursing, 507 Carondelet Street, New Orleans 12, Louisiana.

STAFF NURSE: Generalized program; salary based on education and experience; car essential. Write to Director, West Essex Public Health Nursing Association, 573 Bloomfield Avenue, Verona, New Jersey.

STAFF NURSE: Generalized public health nursing program; liberal personnel policies; travel allowance 8c a mile; salary schedule will be supplied on request. Write to Mrs. Howard A. Watkins, Visiting Nursing Association of Fitchburg, 54 Grove Street, Fitchburg, Massachusetts.

STAFF NURSE: Small county health department in scenic Death Valley and High Sierra mountains; salary range, $3,780-$4,200; 40-hour week; must have own car, mileage allowance; qualifications as set up in NOPHN. Write to Inyo County Health Department, Independence, California.

SUPERVISOR: Generalized family health service; must meet minimum qualifications of NOPHN; salary range $3,600-$4,200 a year. Write to Director, Visiting Nurse Association of Newark, 119 Ridge Street, Newark 4, New Jersey.

STAFF NURSES: Generalized program in friendly rural area that includes Washington State College campus; 40-hour week, vacations, sick leave, retirement benefits; salary based on education and experience; car required, 8c a mile allowance. Write to H. H. Trayner, M.D., Health Officer, Whitman County Health Department, Colfax, Washington.

PUBLIC HEALTH NURSE: certificate required; generalized program in both urban and rural communities of San Francisco Bay area; salary $306 a month to a maximum of $375 in 5 years; car furnished. Write to Alameda County Health Department, 576 Callan Avenue, San Leandro, California.

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STAFF NURSES: Combined program involves school, visiting, and general public health nursing; beginning salary, depending on qualifications, may be at any step in $3,720-$4,500 yearly range; PHN registration required; benefits include 4 weeks vacation, generous sick leave, pension system, and car allowance. Write to Personnel Department, City Hall, Berkeley, California.

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SUPERVISOR: City health department; public health degree required; generalized nursing program; salary $4,200 a year; travel allowance $30 a month; state qualifications and experience. Apply to Mr. H. Zinkel, Chairman, Board of Health, 918 South 24 Street, Manitowoc, Wisconsin.

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